

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled without delay after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified as required by law.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 2 3 1 9 0 5			
1. FOR STATE REGISTRAR				CERTIFICATE OF DEATH			
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH			
FIRST Freda MIDDLE May LAST Spangler				MONTH 12 DAY 10 YEAR 82			
2b. HOUR 0620A.M.							
3. SEX Female		4. RACE White		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	
				MONTH 4 DAY 8 YEAR 95		87 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Good Samaritan Hosp		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Assembler		12b. KIND OF BUSINESS OR INDUSTRY Martin Co.	
13a. STATE Maryland				13b. CITY OR TOWN Middle River		13c. STREET ADDRESS 1300 Shore Road 21220	
14. FATHER'S NAME FIRST Edward MIDDLE Kaufman LAST Kaufman				15. MOTHER'S MAIDEN NAME FIRST Mary MIDDLE Weaver LAST Weaver			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 204 16 7826		17. INFORMANT (Daughter) Mary L. Eisenhart 1312 Second Rd. 21220			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest							30 minutes
4100 DUE TO, OR AS A CONSEQUENCE OF (b) Anterior Myocardial infarction							20 days
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) Pneumonia							10 days
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: None							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 11/18, 19 82, to 12/10, 19 82, that (we) last saw the deceased alive on 12/10, 19 82, and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (do) (did not) view the body after death.							
22b. SIGNATURE Robert C. Griesser MD				DEGREE MD		22c. DATE SIGNED 12/10/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert C. Griesser				22e. ADDRESS 2932 Eutaw Pl, Baltimore MD 21217			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/13/82		23c. NAME OF CEMETERY OR CREMATORY Kaufman Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Davidsville, Somerset Co. Pa.	
24. FUNERAL DIRECTOR Bruzdinski Funeral Home PA 1407 Old Eastern Ave				25a. DATE REC'D. BY REGISTRAR DEC 14 1982		25b. REGISTRAR'S SIGNATURE	



Pennington

white

day

day

Martin Co.

Assebler

1900 Shore Road

Middle River

weaver

day

day

day

(Lantern)

day . 1900 Second St. 1900

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to

Levellville, Tenn. Co. 1900

Levellville, Tenn. Co. 1900

1900

1900

Levellville, Tenn. Co. 1900

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 7 days after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 1-800-368-5878.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 3 1 9 0 6

FOR  
1 - STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Velizarii Spassoff</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>12 / 14 / 82</b>		2b. HOUR <b>1:35 P.M.</b>
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>11 13 08</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>74</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Bulgaria</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.	
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>South Baltimore General Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Health Director</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>School</b>
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b> 13b. COUNTY <b>Anne Arundell</b> 13c. CITY OR TOWN <b>Linthicum</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>5700 Hammonds Ferry Rd.</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Alexander Spassoff</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Victoria POCOJANOVA</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>218 52 4538</b>		17. INFORMANT ADDRESS <b>LINTHICUM, MD. 21227</b> <b>5700 HAMMONDS FERRY RD.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory arrest</b> 1533 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b>Metastatic carcinoma of sigmoid</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>1 year</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <b>1</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>December 2</b> , 19 <b>82</b> , to <b>December 14</b> , 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>December 14</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Lewis Dean Mitchell</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>12/14/82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Lewis Dean Mitchell</b>		22e. ADDRESS <b>3001 S. Hanover St. Baltimore, Md 21061</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>CREMATION</b>		23b. DATE <b>12-15-82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>LOUDON PARK</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE CITY MARYLAND</b>		23e. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE CITY MARYLAND</b>			
24. FUNERAL DIRECTOR NAME <b>HUBBARD FUNERAL HOME, INC.</b>		ADDRESS <b>4107 WILKENS AVE.</b>		25a. DATE OF DEATH <b>DEC 15 1982</b>	
25b. REGISTRAR'S SIGNATURE <b>John J. Ganiel</b>					

BP



DEC 12 1963  
J. J. J. J.



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 2 3 1 9 0 7

FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Beatrice</b>			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>12-27-82</b>			2b. HOUR M <b>4:19A</b>		
3. SEX <b>FE</b>	4. RACE <b>Black</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>9 18 98</b>	6. AGE (IN YEARS) LAST BIRTHDAY <b>84</b> YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN	IF UNDER 24 HRS.	7c. DATE PRONOUNCED DEAD <b>12-27-82</b>	2d. HOUR M <b>4:19A</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>S.G.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b>		
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>1417 Longwood Street</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker at home</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>MD</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>1417 N. Longwood St</b>
14. FATHER'S NAME FIRST MIDDLE LAST <b>Doc Craffon</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>FONA 21216</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO.		17. INFORMANT <b>HABAKKUK SPEAKS</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic carcinoma of breast</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE <b>Margarita A. Korell</b>		TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER					DATE SIGNED <b>12-27-82</b>	
EXAMINER'S NAME (TYPE OR PRINT) <b>Margarita A. Korell, M.D.</b>		ADDRESS <b>111 Penn Street</b>						
23a. BURIAL, CREMATION, REMOVAL (BY) <b>Burial</b>		23b. DATE <b>12/31/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Green Hill</b>		23d. LOCATION (BY TOWN) COUNTY STATE <b>Baltimore MD 21225</b>		
24. FUNERAL DIRECTOR <b>Thomas Gail A. Hunt</b>				25a. DATE REC'D BY REGISTRAR <b>JAN 3 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Smith</b>		

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE MEDICAL EXAMINER SHOULD EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH VITAL RECORDS. 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

May 1, 1911

Dear Sir:

I have the honor to acknowledge the receipt of your letter of the 28th inst.

and in reply to inform you that the same has been forwarded to the

proper authorities for their consideration.

I am, Sir, very respectfully,

Yours very truly,

Wm. H. Hays

Assistant Secretary

U. S. Department of Agriculture

Washington, D. C.

Very truly yours,

Wm. H. Hays

Assistant Secretary

U. S. Department of Agriculture

Washington, D. C.

Very truly yours,

Wm. H. Hays

Assistant Secretary

U. S. Department of Agriculture

Washington, D. C.

Very truly yours,

Wm. H. Hays



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 3 1 9 0 8

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Cola L. Speaks			2a. DATE OF DEATH MONTH DAY YEAR 12 7 82			2b. HOUR M M				
3. SEX male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 6 1 16		6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. IF UNDER 24 HRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Greenville, SC.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.				
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4701 Park Heights Avenue				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Maryland			13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 4701 Park Heights Ave 21215	
14. FATHER'S NAME FIRST MIDDLE LAST John Speaks			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Beatrice Crafton							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 219-01-1006		17. INFORMANT ADDRESS Ruth Speaks 4701 Park Heights Ave.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> 1629 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Possibly due to pulmonary hemorrhage</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Lung Adenocarcinoma</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Hours</u> <u>6 months</u>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>Oct 31</u> , 19 <u>82</u> , to <u>Dec 7</u> , 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>Dec 7</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>O.O. Lawoyin</u>			DEGREE <u>M.D.</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <u>12/9/82</u>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) OLUSEGUN O. LAWLOYIN			22e. ADDRESS 200 W GOLD SPRING LANE BALTIMORE, MD.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 12/13/82		23c. NAME OF CEMETERY OR CREMATORY Md. Veteran Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Crownsville, Md.			
24. FUNERAL DIRECTOR NAME Wm. C. March F/H Inc. 1101 E. North Ave.			25a. DATE REC'D. BY REGISTRAR DEC 10 1982		25b. REGISTRAR'S SIGNATURE <u>John J. Carver</u>					

U.S. DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D.C. 20535

100-100000-1



100-100000-1  
JUL 10 1963  
FBI - NEW YORK

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE					8 2 3 1 9 0 9	
1 - FOR STATE REGISTRAR			CERTIFICATE OF DEATH			
1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR
Raymond R. Spencer			Dec. 9, 1982			3 PM
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
Male	White	Sept. 29, 1903	79 YRS.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH			
West Virginia	U.S.A.		Baltimore MD.			
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Baltimore	Long Green Nursing Home		Retired Teacher		Balt. City	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13b. CITY OR TOWN		13c. STREET ADDRESS	
Maryland			Baltimore		1301 Walters Ave 21239	
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			
Harry G. Spencer			Irma Davies			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS		
No		217-12-5123		Mrs Dorothy Spencer Same		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>coronary of pericardium</u> 1579 DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs</u>						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>carbon monoxide poisoning</u>						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
Dec 2, 1982		Gastric ulcer		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>12/13/82</u> , 19 <u>82</u> , to <u>12/19</u> , 19 <u>82</u> , that (I) (we) lost <u>saw the deceased alive on</u> <u>12/13/82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <u>William Renner</u> DEGREE				22c. DATE SIGNED 12/10/82		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS		
William Renner MD				3222 St. Paul St. Baltimore, Md.		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE
Burial		12/13/82		Parkwood		***** Baltimore, Md
24. FUNERAL DIRECTOR NAME ADDRESS				25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE		
Leonard J. Ruck Inc. Baltimore, Maryland				DEC 13 1982 John J. Cabell		





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 2 3 1 9 1 0			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Mamie C. Spivey</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>12 30 82</b>		2b. HOUR <b>M</b>	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>11 26 1911</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS <b>71</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Baltimore City Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13. STATE COUNTY <b>Maryland Baltimore</b>				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>7004 River Drive Road</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Daniel Yost</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Charlotte</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>				16b. SOCIAL SECURITY NO. <b>213-09-3837</b>		17. INFORMANT ADDRESS <b>Daniel G. Spivey 3041 Liberty Parkway Balto. MD 21222</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute myocardial infarction</b> <b>4100</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerotic Cardiovascular ds.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <b>Arteriosclerosis, generalized.</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b> <b>20 year</b>							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>1976</b> , 19 <b>12-30</b> , to <b>12-30</b> , 19 <b>82</b> , that (I) (we) lost saw the deceased alive on <b>12-30</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE DEGREE <b>Hector Feliciano, M.D.</b>				22c. DATE SIGNED <b>12-31-82</b>		22d. ADDRESS <b>7200 North Point Road</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>1/3/83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Maryland</b>	
24. FUNERAL DIRECTOR NAME <b>Duda-Ruck, Inc.</b>				25a. DATE REC'D BY REGISTRAR <b>JAN 5 1983</b>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	
26. ADDRESS <b>7922 Wise Avenue Dundalk, MD. 21222</b>							

1888 JAN.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 3 1 9 1 1

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Josephine I. Spruel</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>12-2-82</b>			2b. HOUR <b>8:10 P.M.</b>			
3. SEX <b>FEMALE</b>		4. RACE <b>Col V</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>12-17-896</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>85</b>		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN) <b>VIRGINIA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY MD</b>			
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>John L. Deaton Medical Center</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13b. COUNTY <b>Maryland</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. STREET ADDRESS <b>626 W. Lanvale St</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Thomas Anderson</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Ella Washington</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>NO</b>		16b. SOCIAL SECURITY NO.		17. INFORMANT NAME ADDRESS <b>Mrs. Marie Diggs 2205 Orem Ave.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PROBABLE CEREBROVASCULAR ACCIDENT</b> <b>4360</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>STROKE IN OCTOBER 1981. LARGE DECUBITUS ULCERS. ANOREXIA AND DEHYDRATION</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>Nov 16</b> , 19 <b>82</b> , to <b>Dec 2</b> , 19 <b>82</b> , that (I) (we) lost saw the deceased alive on <b>Dec 2</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Frank R. Jackson</b>				DEGREE <b>MD</b>				22c. DATE SIGNED <b>12/3/82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>FRANK R. JACKSON</b>				22e. ADDRESS <b>J. L. DEATON CTR BALTO MD</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>12-8-82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Zion Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Landsdowns Spd</b>		23e. DATE REC'D BY REGISTRAR <b>DEC 13 1982</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>Joseph L. Russ 2222 W. North Ave</b>				25a. DATE REC'D BY REGISTRAR <b>DEC 13 1982</b>					

MEDICAL CERTIFICATION

*[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page.]*



DEC 13 1903  
J. L. G. G. G.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR		
FIRST MIDDLE LAST WARREN STAFFORD			MONTH DAY YEAR 12 23 82			4:25 AM		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR		
M	B	MONTH DAY YEAR 07 30 55	27 YRS.			MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>						
MD.	USA	9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore city MD.						
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY	
Baltimore	University of MD Hospital			Laborer				
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13b. CITY OR TOWN			13c. INSIDE CITY LIMITS?		
13a. STATE COUNTY MD. Harchester - Cambridge			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13c. STREET ADDRESS 713 Rosemount Ave		
14. FATHER'S NAME FIRST MIDDLE LAST Osca			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST O'Reilly Stafford					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT ADDRESS		
			214-60-7515			O'Reilly Stafford 713 Rosemount Ave		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 2051 IMMEDIATE CAUSE (a) Pulmonary arrest DUE TO, OR AS A CONSEQUENCE OF: (b) Chronic Myelogenous leukemia - Blast crisis (c) CNS Leukemia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): Infection GI bleed.								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from Dec 13, 19 82, to Dec 23, 19 82, that (I) (we) lost saw the deceased alive on Dec 23, 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE S. S. S. MD			DEGREE			22c. DATE SIGNED 12/23/82		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Lawrence M SIGMAN			22e. ADDRESS University of Md Hospital					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial			12/30/82		Bethel Ceme. Cambridge Harchester MD.			
24. FUNERAL DIRECTOR NAME ADDRESS ST. Clair Funeral Home 521 High St. MD 21201			25a. DATE RECD. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
			DEC 28 1982			John J. Ganiel		

BP



DEC 20 1950

John Smith



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 2 3 1 9 1 3			
1. STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>John Charles Starcevich</b>				2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
				12-1-82		10 <sup>05</sup> PM	
3. SEX <b>Male</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)	
				FEB. 25, 1947		35 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>FLORIDA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
						<b>BALTIMORE CITY MD.</b>	
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Keswick Nursing Home</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>NEVER WORKED</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>FLORIDA</b>		13b. COUNTY <b>STANARDSVILLE</b>		13c. CITY OR TOWN <b>STANARDSVILLE</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>GEORGE MICHAEL STARCEVICH</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>SHIRLEY RUTH MITCHELL</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>267-80-4100</b>	
				17. INFORMANT ADDRESS <b>SHIRLEY R. MOORE RT.1 BOX 442</b>		17b. STREET ADDRESS <b>ROUTE 1</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <b>3439</b> IMMEDIATE CAUSE (a) <b>uremia</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>chronic glomerulonephritis</b>							
(c) <b>Cerebral Palsy</b>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>NO</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>7-1</b> , 19 <b>76</b> , to <b>12-1</b> , 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>12-1</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>E. H. W. W. W.</b> DEGREE <b>MD</b>				22c. DATE SIGNED <b>12-1-82</b>		22d. PHYSICIAN'S NAME (TYPE OR PRINT)	
				22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>CREMATION</b>		23b. DATE <b>DEC. 3, 1982</b>		23c. NAME OF CEMETERY OR CREMATORY <b>GREEN MOUNT CEM.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE MD.</b>	
24. FUNERAL DIRECTOR NAME <b>MITCHELL-WIEDEFELD HOME</b> ADDRESS <b>6500 YORK RD. 21212</b>				25a. DATE REC'D. BY REGISTRAR <b>DEC 3 1982</b> REGISTRAR'S SIGNATURE <b>John J. Smith</b>			

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RECEIVED

RECEIVED

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RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE					8 2 3 1 9 1 4					
1 - FOR STATE REGISTRAR					REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) Catherine Steimer					2a. DATE OF DEATH MONTH DAY YEAR 12 21 82			2b. HOUR 10:16 PM		
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 9 3 03		6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Argentina		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.				
10. CITY OR TOWN OF DEATH Balt. City		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Lutheran Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY Housewife		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland					13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Michael McDonnell					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Kelly					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No					16b. SOCIAL SECURITY NO. 557203519		17. INFORMANT ADDRESS Margaret E. Gallien, 2707 N. Calvert St.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ASCD, Pneumonia, R/o Pulm embol. 4292 DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) DUE TO, OR AS A CONSEQUENCE OF _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: _____										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE S. Suwanagool					DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 12/2/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) S. Suwanagool					22e. ADDRESS Lutheran Hospital					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE 12/22/82		23c. NAME OF CEMETERY OR CREMATORY Westview Memorial		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland			
24. FUNERAL DIRECTOR NAME Burgess Funeral Home, 3631 Falls Rd. 21211					25a. DATE REC'D. BY REGISTRAR DEC 23 1983		25b. REGISTRAR'S SIGNATURE John J. Lohr			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified at once.

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 3 1 9 1 5

REG. NO.

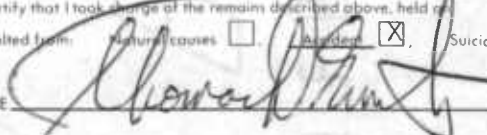
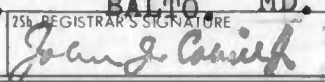
1. DECEASED NAME (TYPE OR PRINT) <b>Victor G. Stein, Sr.</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>Dec. 4, 1982</b>		2b. HOUR <b>8:15 PM</b>	
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>June 3, 1910</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>72</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Balto., Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>St. Agnes Hospital</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City, MD.</b>		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Stock Clerk</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Hardware St.</b>		13a. STREET ADDRESS <b>736 Edmondson Ave.-Rear</b>		
13b. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13c. CITY OR TOWN <b>Catonsville</b>		13d. STREET ADDRESS <b>21228.</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Charles E. Stein</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Gertrude E. Parrish</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		
16b. SOCIAL SECURITY NO. <b>214-05-3316</b>		17. INFORMANT <b>Mrs. Doris C. Stein</b>		17b. ADDRESS <b>Catonsville, Maryland, 21228.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <b>4292</b> IMMEDIATE CAUSE (a) <b>Caducous arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Digestive h.s. failure</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Thrombotic C.D. dis.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>C.D. P.D.</b>						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <b>Home</b>		
21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>1212 1/2 56 12 14 19 82</b>		22a. I certify that (1) (this hospital) attended the deceased from <b>12/2/82</b> to <b>12/4/82</b> and that in (my) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.		22b. SIGNATURE <b>C. S. MASS</b>		
22c. DATE SIGNED <b>12/4/82</b>		22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>C. S. MASS</b>		22e. ADDRESS <b>433 Nottingham Rd. 21229</b>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Dec. 8, 1982</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cem.</b>		
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Maryland</b>		24. FUNERAL DIRECTOR NAME <b>Bierling Funeral Home</b>		25a. DATE REC'D. BY REGISTRAR <b>DEC 6 - 1982</b>		
25b. REGISTRAR'S SIGNATURE <b>John J. Connel</b>		25c. ADDRESS <b>736 E. ... Catonsville, Md. 21228</b>		25d. ADDRESS <b>736 E. ... Catonsville, Md. 21228</b>		





TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM-PM 3. RETAIN PAGE 5. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 8 2 3 1 9 1 6	
1. DECEASED NAME (TYPE OR PRINT) <b>Bruce FRANK Stengel</b>						2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/>		MONTH DAY YEAR <b>12 11 82</b>		2b. HOUR <b>M</b>	
3. SEX <b>MALE</b>		4. RACE <b>CAUCAS.</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>09 09 53</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>29</b> YRS.		IF UNDER 24 YRS. MONTHS DAYS HOURS MIN.		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>12 11 82</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>				7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City, MD.</b>	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>2629 E. Monument Street</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>TECHNICIAN</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>AMUSEMENTS</b>	
13a. STATE <b>MARYLAND</b>				13b. COUNTY <b>---</b>		13c. CITY OR TOWN <b>BALTIMORE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>2629 E. MONUMENT ST. 21205</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>JOHN STENGEL</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>LORRAINE SITES</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>NO</b>				16b. SOCIAL SECURITY NO. <b>213646835</b>		17. INFORMANT ADDRESS <b>JOHN STENGEL P.O. BOX 461 BELAIR 21014</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: <b>8902</b> IMMEDIATE CAUSE (a) <b>Smoke &amp; soot inhalation &amp; Acute carbon monoxide intoxication</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>3:42 PM 12 11 82</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>House fire</b>					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>home</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>2629 E. Monument St, Balto. City, Md.</b>					
22a. I certify that I took charge of the remains described above, held in death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE 				TITLE (SPECIFY) M.D. <b>Deputy Chief</b>				DATE SIGNED <b>12/11/82</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>Thomas D. Smith, M.D.</b>				ADDRESS <b>111 Penn ST. Balto., MD.</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>				23b. DATE <b>12/15/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>OAKLAWN</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTO. BALTO. MD.</b>	
24. FUNERAL DIRECTOR NAME <b>John J. Connel</b>				ADDRESS <b>21205 2716-18 E Monument St</b>		25a. DATE REC'D. BY REGISTRAR <b>DEC 14 1982</b>		25b. REGISTRAR'S SIGNATURE 			

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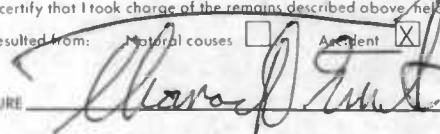
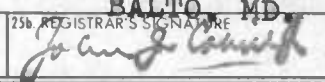
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BALTIMORE

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM-PM 3. RETAIN PAGE 5 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 4 2 3 1 9 1 7	
FOR 1- STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) <b>Lorraine SELMA Stengel</b>										2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR <b>12 11 82</b>	
3. SEX <b>FEMALE</b>		4. RACE <b>CAUCAS.</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>11 27 19 63</b>		6. AGE (IN YEARS) (LAST BIRTHDAY) <b>19 YRS.</b>		IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.		2c. DATE PRONOUNCED DEAD <b>12 11 82</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City,</b> MD.					
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>2629 E. Monument Street</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSEWIFE</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>----</b>			
13. STATE <b>MARYLAND</b>										13b. COUNTY <b>----</b>	
13c. CITY OR TOWN <b>BALTIMORE</b>										13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS <b>2629 E. MONUMENT ST 21205</b>											
14. FATHER'S NAME FIRST MIDDLE LAST <b>JAMES G. SITES</b>										15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>EMMA WERNER</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>216096040</b>		17. INFORMANT ADDRESS <b>21014 JOHN STENGEL P.O. BOX 461 BELAIR</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: <b>8902</b> IMMEDIATE CAUSE (a) <b>Smoke &amp; soot inhalation &amp; Acute carbon monoxide intoxication</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>3:42 PM 12 11 82</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>House fire</b>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>house</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>2629 E. Monument St., Balto. City, Md.</b>					
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE 				TITLE (SPECIFY) M.D. <b>Deputy Chief</b>				DATE SIGNED <b>12/11/82</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>Thomas D. Smith, M.D.</b>				ADDRESS <b>111 Penn St. Balto., MD.</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>				23b. DATE <b>12/15/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>OAKLAWN</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTO. BALTO. MD.</b>			
24. FUNERAL DIRECTOR NAME <b>John W. Smith</b>				ADDRESS <b>2716-18 E. Monument St.</b>		25a. DATE REC'D. BY REGISTRAR <b>DEC 14 1982</b>		25b. REGISTRAR'S SIGNATURE 			



RECEIVED JAN 11 1963

USA

ARMY

BALTIMORE

JAMES

BIRMINGHAM

216-98010

JOHN STEWART, P.O. BOX 101 BALTIMORE  
M.D. 21201

*[Handwritten signature]*

RECEIVED JAN 11 1963

UNDELIVERED

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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REG. NO.

1- FOR  
STATE  
REGISTRAR

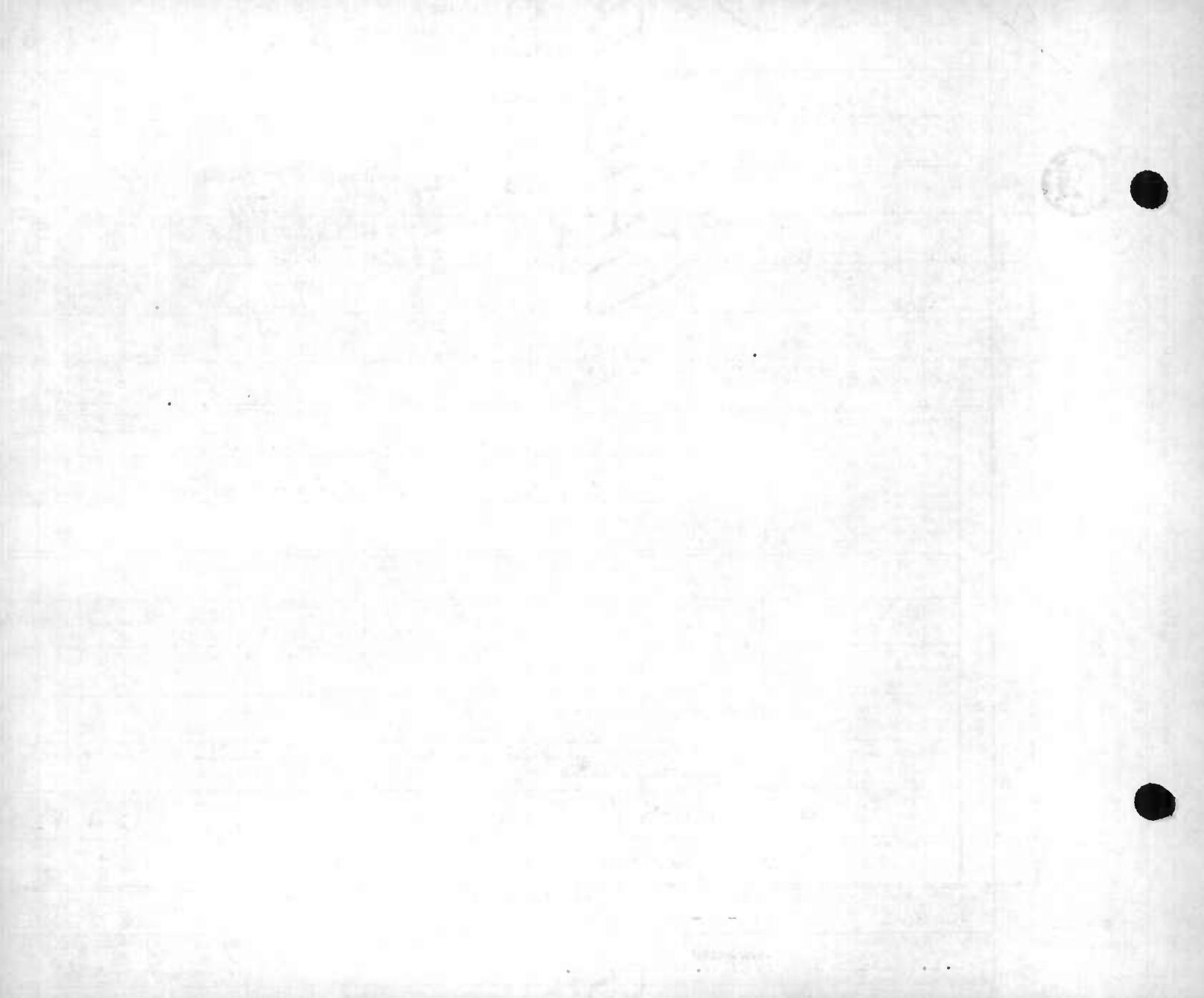
1 DECEASED NAME (TYPE OR PRINT) <b>Ethel Stephens</b>		2a DATE OF DEATH MONTH DAY YEAR <b>12-9-82</b>		2b HOUR <b>5 05 A.M.</b>	
3 SEX <b>FEMALE</b>		4 RACE <b>BLACK</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>3 28 1906</b>	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>SOUTH CAROLINA</b>		7b CITIZEN OF WHAT COUNTRY? <b>US</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>76</b>	
10 CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>PROVIDENT HOSPITAL</b>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>CITY</b> MD.	
12a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 12a STATE <b>MARYLAND</b>		13b COUNTY <b>BALTIMORE</b>		13c INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>LOUIS E. GADSDEN</b>		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>LAURA JACKSON</b>		13d STREET ADDRESS <b>914 WHITELOCK ST. 21217</b>	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>NO</b>		16b SOCIAL SECURITY NO. <b>4292</b>		17 INFORMANT ADDRESS <b>LILLIAN SAUNDERS NEWBERRY, S. CAROLINA 29108</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardio-respiratory arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>ASCVS, Dehydration</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from <b>12-8-82</b> , to <b>12-9-82</b> , that (I) (we) last saw the deceased alive on <b>12-9-82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b SIGNATURE <b>Howardoss</b>		DEGREE <b>MD</b>		22c DATE SIGNED <b>12-9-82</b>	
22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>H. Devadoss</b>		22e ADDRESS <b>Provident-HOSPITAL</b>			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>REMOVAL</b>		23b DATE <b>12-18-82</b>		23c NAME OF CEMETERY OR CREMATORY <b>ORANGEBURG CEMETERY</b>	
24 FUNERAL DIRECTOR NAME <b>E.L. PHILLIPS</b>		ADDRESS <b>1721 N. MONROE ST.</b>		23d LOCATION CITY OR TOWN COUNTY STATE <b>ORANGEBURG SOUTH CAROLINA</b>	
25a DATE REC'D. BY REGISTRAR		25b REGISTRAR'S SIGNATURE <b>DEC 16 1982 John J. Conner</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or reinterment.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at the time of death.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 3 1 9 1 9

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>DAVID</b>			2a. DATE OF DEATH MONTH <b>12</b> DAY <b>8</b> YEAR <b>82</b>			2b. HOUR <b>10<sup>30</sup> AM</b>			
3 SEX <b>MALE</b>		4 RACE <b>Negro</b>		5. DATE OF BIRTH MONTH <b>06</b> DAY <b>06</b> YEAR <b>09</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>73</b> YRS.		IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b> IF UNDER 24 HRS. HOURS <b></b> MIN. <b></b>	
7 BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>PENNA.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>US</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>BALto. City, MD.</b>			
10. CITY OR TOWN OF DEATH <b>BALto.</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>BON SECOURS HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>MD.</b>		13b. COUNTY <b>BALto.</b>		13c. CITY OR TOWN <b>BALto.</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>701 N. Arlington AVE.</b>	
14 FATHER'S NAME FIRST <b>David</b> MIDDLE <b>Stevens</b> LAST <b>Sr</b>				15. MOTHER'S MAIDEN NAME FIRST <b>Eleanor</b> MIDDLE <b>Jones</b> LAST <b>Jones</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. <b>183-16-4090</b>		17. INFORMANT <b>William Stevens</b> ADDRESS <b>2408 Loyola Ave Apt 263</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebrovascular Accident</b> <b>4360</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) <b></b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Immediate</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>OLD CVA.; Intestinal Bleeding;</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>11/5/82</b> 19 to <b>12/8/82</b> 19, that (I) (we) lost <b>saw the deceased alive on 12/7/82</b> 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>[Signature]</b>		DEGREE <b>M.D.</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>12/11/82</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>S.S. DANG</b>		M.D.		22e. ADDRESS <b>40 DUNDALK AVE. Balto Md 21222</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>2/1/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arbiter Memorial</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Md</b>			
24. FUNERAL DIRECTOR <b>[Signature]</b>		ADDRESS <b>3207 W. [unclear]</b>		25a. DATE REC'D. BY REGISTRAR <b>DEC 13 1982</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			



DAVID

MALE

12-1-1941

12-1-1941

25

DAVIDSON

X

12

DAVIDSON, BENJAMIN HOSPITAL

MD. CHAIRMAN, DAVIDSON X 101 N. ALPINE

ELIZABETH

12-1-1941

12-1-1941

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner and the mortician must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		REG. NO.							
1 DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH	
THELMA		STEVENSON						MONTH DAY YEAR	
3 SEX		4 RACE		5. DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		7b. HOUR	
Female		Black		MONTH DAY YEAR		68 YRS.		12 2 82 3 <sup>00</sup> PM	
7 BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH			
NC		U.S.A.				Baltimore City		MD.	
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Baltimore		Lutheran Hospital							
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
MD				Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1046 Ellicott Drive	
14 FATHER'S NAME		15. MOTHER'S MAIDEN NAME							
FIRST MIDDLE LAST		FIRST MIDDLE LAST							
Roscoe		Perry		Florence		Lindsey			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17 INFORMANT		ADDRESS			
NO		237-16-9324		Kay Clay		3609 Cottage Avenue			
18 CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiorespiratory arrest</u> 5609 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Respiratory failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Pneumonia - Sepsis</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>CARCINOMA ENDOMETRIUM - RENAL FAILURE</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
NOV 82		INTESTINAL OBSTRUCTION		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>11/10/82</u> to <u>12/2/82</u> , that (I) (we) lost saw the deceased alive on <u>12/2/82</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED			
<u>1/1/83</u>						12-2-82			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS							
PELAYO E. CORREA		LUTHERAN HOSPITAL							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial		12/7/82		King Memorial Pk		Balto. Co. MD			
24 FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Wm. C. March F/H, Inc. 1101 E. North		DEC 6 - 1982		<u>John J. Connel</u>					



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and item 18 completed.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8	2	3	1	9	2	1
1- STATE REGISTRAR										REG. NO.						
1. DECEASED NAME (TYPE OR PRINT) <b>MABEL I STEWARD.</b>										2a. DATE OF DEATH MONTH <b>DEC</b> DAY <b>7</b> YEAR <b>1982</b>				2b. HOUR <b>7A</b> M		
3. SEX <b>Female</b>			4. RACE <b>Caucasian</b>			5. DATE OF BIRTH MONTH <b>10</b> DAY <b>15</b> YEAR <b>1898</b>			6. AGE (IN YEARS LAST BIRTHDAY) <b>84</b> YRS.			IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>		IF UNDER 24 HRS. HOURS <b></b> MIN <b></b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>CITY</b> MD.							
10. CITY OR TOWN OF DEATH <b>BALTIMORE City</b>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>MFL NURSING HOME City Hosp.</b>							12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>RETIRED</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>CONT. CAN</b>			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) <b>Md</b>			13b. COUNTY <b>Balto.</b>			13c. CITY OR TOWN <b>Balto.</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS <b>133 S. EATON STREET</b>				
14. FATHER'S NAME FIRST <b>UNKNOWN</b> MIDDLE <b></b> LAST <b></b>					15. MOTHER'S MAIDEN NAME FIRST <b>Bessie</b> MIDDLE <b>Pyle</b> LAST <b></b>											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>					16b. SOCIAL SECURITY NO. <b>217-01-0514</b>					17. INFORMANT ADDRESS <b>Frieda A. Steward, 133 S. EATON ST.</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>4149</b> IMMEDIATE CAUSE (a) <b>Cardiorespiratory Arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Ischemic Heart Disease, Atrial fibrillation</b> years. DUE TO, OR AS A CONSEQUENCE OF (c) <b></b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b></b>						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I a <b>Multiple strokes and T.I.A.'s. L hemiparesis.</b>																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED							20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE										
22a. I certify that (I) (this hospital) attended the deceased from <b>8 Nov</b> 19 <b>82</b> to <b>7 Dec</b> 19 <b>82</b> , that I (we) last saw the deceased alive on <b>7 Dec</b> 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																
22b. SIGNATURE <b>Edmund G. Beacham M.D.</b>			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <b>7 Dec 82</b>							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>E. G. BEACHAM M.D.</b>						22e. ADDRESS <b>BALTIMORE City HOSPITALS</b>										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>12-10-82</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Balto. Cemetery</b>			23d. LOCATION CITY OR TOWN <b>Balto.</b> COUNTY <b>Ht.</b> STATE <b></b>							
24. FUNERAL DIRECTOR NAME <b>Joseph N. Zannino Fun. H.</b> ADDRESS <b>263 S. CONKUN</b>						25a. DATE REC'D. BY REGISTRAR <b>DEC 9 - 1982</b>			25b. REGISTRAR'S SIGNATURE <b>John J. Smith</b>							



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DEC 9 - 1952



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 3 1 9 2 2

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>CALVIN STEWART</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>12/21/82</b>		2b. HOUR <b>7:49p</b>
3. SEX <b>male</b>	4. RACE <b>Black</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>2 19 18</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>64</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.		
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>THE JOHNS HOKINS HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>	13c. CITY OR TOWN <b>Baltimore</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <b>2010 E. North Avenue 21213</b>
14. FATHER'S NAME FIRST MIDDLE LAST <b>N/A</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>		16b. SOCIAL SECURITY NO. <b>217-05-7329</b>		17. INFORMANT ADDRESS <b>Julia Stewart 46 Stonecroft Road 21229</b>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

**Cardiac Arrest**APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH**5 min**

**3030**  
Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b)

**Pneumonia**

DUE TO, OR AS A CONSEQUENCE OF

(c)

**Alcohol Abuse**

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)

## MEDICAL CERTIFICATION

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>11/29</b> , 19 <b>82</b> , to <b>12/21</b> , 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>12/21</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <b>R A Lange MD</b>	DEGREE <b>MD</b>	ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED <b>12/21/82</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>R A LANGE MD</b>		22e. ADDRESS <b>JOHNS HOPKINS HOSPITAL</b>	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>	23b. DATE <b>12/29/82</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Md. Veteran Cem.</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>Crownsville Md</b>
24. FUNERAL DIRECTOR NAME ADDRESS <b>Wm. C. March F/H Inc. 1101 E. North Avenue</b>		25a. DATE RECEIVED BY REGISTRAR <b>DEC 28 1982</b>	
		25b. REGISTRAR'S SIGNATURE <b>John J. Connel</b>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

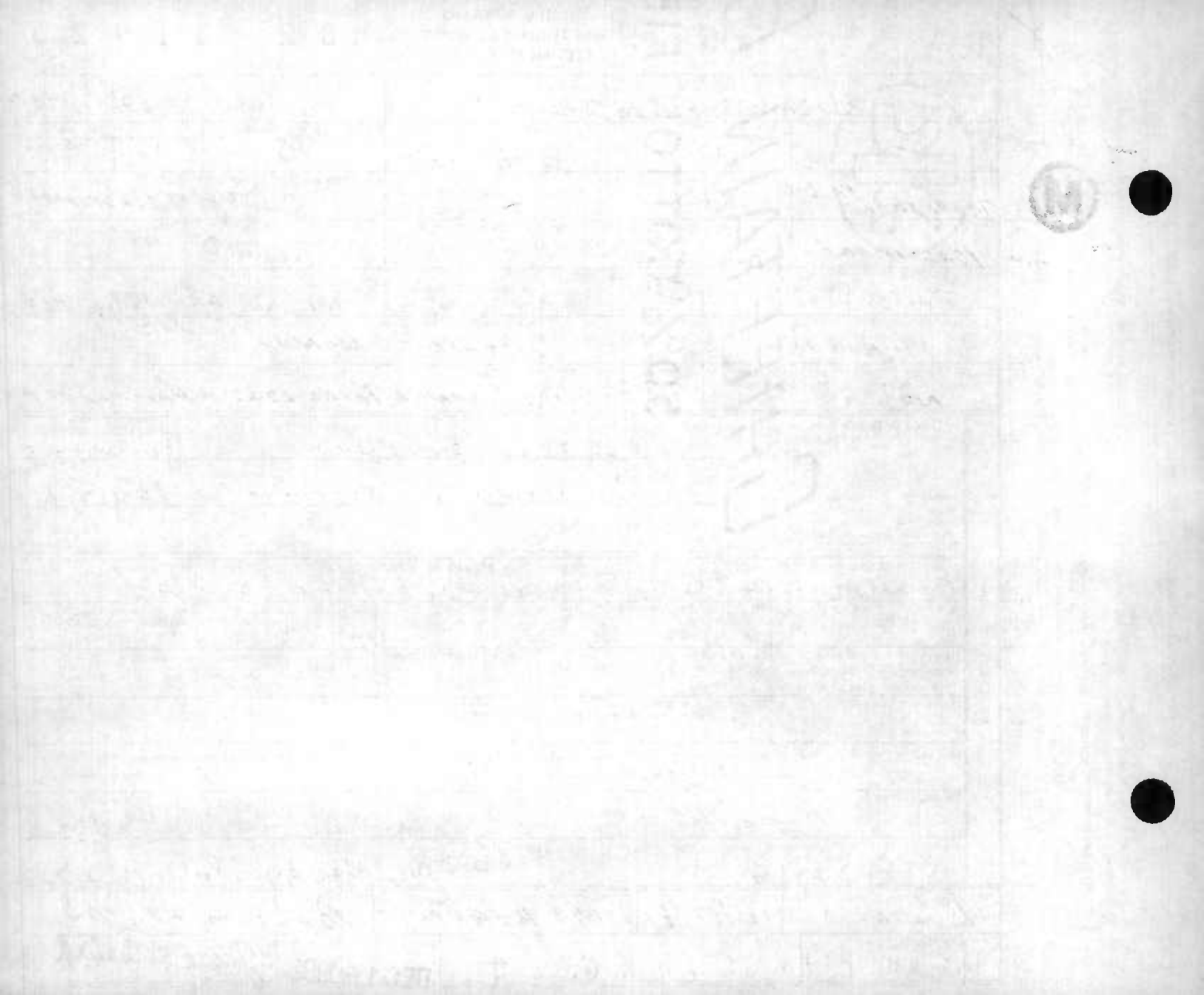
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrars, it should be detached for use on the burial-transit permit. Their please remove carbon papers. Pages 1 and 2 should be kept with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or reinterment. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

FOR  
1- STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 3 1 9 2 3

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) ELIZABETH ELIZASTEWART			2a. DATE OF DEATH MONTH DAY YEAR 12 12 82			2b. HOUR 11:14 PM M					
3. SEX F		4. RACE B		5. DATE OF BIRTH MONTH DAY YEAR 5 27 07		6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.			
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) GREENSBORO NC		9. CITIZEN OF WHAT COUNTRY? US		10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		11. BALTIMORE CITY OR COUNTY OF DEATH City of Baltimore MD					
12. CITY OR TOWN OF DEATH BALTIMORE		13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BON SECOURS HOSP				14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED		15. KIND OF BUSINESS OR INDUSTRY			
16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 16a. STATE BALTO.			16b. COUNTY BALTO.		16c. CITY OR TOWN BALTO.		16d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		16e. STREET ADDRESS 701 N. ARKINGTON AVE 21214		
17. FATHER'S NAME FIRST MIDDLE LAST J. R. KNOX			18. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST BEATRICE MONROE			19. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO				20. SOCIAL SECURITY NO. 217-22-5422	
21. INFORMANT ADDRESS CLARENCE TORRES 2228 W. FAIRMOUNT AVE											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cardio-vascular disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4292									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u> <u>Longstanding</u>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) <u>Embolism (C) leg, Congestive Heart Failure, Arthritis</u>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I, OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>12/10/82</u> , 19____, to <u>12/13/82</u> , 19____, that (I) (we) last saw the deceased alive on <u>12/11/82</u> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>ESJ</u>			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <u>12/13/82</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) S. S. DAVIS			22e. ADDRESS 40 Dundalk Ave Baltimore 21222								
23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT) Burial			23b. DATE 12/17/82			23c. NAME OF CEMETERY OR CREMATORY Mt Airy			23d. LOCATION Baltimore, MD		
24. FUNERAL DIRECTOR NAME Marshall P. Hayes			ADDRESS 638 N. Gilman St.			25. DATE REC'D. BY REGISTRAR DEC 14 1982			25. REGISTRAR'S SIGNATURE John J. Lohr		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with a local health department with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 3 1 9 2 4 REG. NO.			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Helen Feryl STIRLING</i>				12. 17. 82 15 <sup>00</sup> PM			
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>Feb. 9, 1912</i>		6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR IF UNDER 24 HRS. <i>70</i> YRS. MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>BALTIMORE CITY</i> MD.	
10. CITY OR TOWN OF DEATH <i>BALTIMORE</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>UNION MEMORIAL HOSPITAL</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Home maker</i>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <i>Maryland</i>				13b. COUNTY <i>-----</i>		13c. CITY OR TOWN <i>Baltimore</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Seth Peal</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Blanche Hand</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <i>No</i>				16b. SOCIAL SECURITY NO. <i>218-46-3204</i>		17. INFORMANT ADDRESS <i>Dorothy Dippel 315 Murdock Rd. 21212</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							
PART I. DEATH WAS CAUSED BY:							
IMMEDIATE CAUSE (a) <i>Complete left sided embolic stroke</i>							
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Severe atherosclerotic carotid disease</i>							
DUE TO, OR AS A CONSEQUENCE OF (c) <i>years</i>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a <i>Hypertension</i>							
19a. DATE OF OPERATION <i>12-16-82</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Tubercle attacks</i>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>Jan</i> , 19 <i>82</i> , to <i>12.17</i> , 19 <i>82</i> , that (I) (we) last saw the deceased alive on <i>12.17</i> , 19 <i>82</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (and) (do not) view the body after death.							
22b. SIGNATURE <i>[Signature]</i>		DEGREE <i>M.D.</i>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>12.17.82</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>W. F. B. L. E. Y. J. U. M. D.</i>		22e. ADDRESS <i>3809 Greenmount Avenue Balto 21213</i>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>Dec 20, 82</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Cathedral Cemetery</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Baltimore, Maryland</i>	
24. FUNERAL DIRECTOR NAME <i>Dippel Funeral Homes, Inc.</i>		ADDRESS <i>7110 Belair Road Baltimore, Md.</i>		25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <i>DEC 21 1982 [Signature]</i>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 3 1 9 2 5			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST HORACE E. STOKES				2a. DATE OF DEATH MONTH DAY YEAR 12 16 82		2b. HOUR 9:40A M	
3. SEX male		4. RACE Col		5. DATE OF BIRTH MONTH DAY YEAR 12-2-1908		6. AGE (IN YEARS LAST BIRTHDAY) YRS 74	
7. BIRTHPLACE (STATE OR FOREIGN) Baltimore, Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) VAMC LOCH RAVEN BALTO. LMD 21218		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Grocery Store Supervisor		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE Maryland				13b. COUNTY Baltimore		13c. CITY OR TOWN BALTO.	
14. FATHER'S NAME FIRST MIDDLE LAST Horace Stokes				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Martha Veney			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 218 03 7346		17. INFORMANT ADDRESS Mrs. Sumita V. Stokes 1814 Druid Hill Ave.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> 1850 DUE TO, OR AS A CONSEQUENCE OF (b) <u>congestive heart failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>metastatic prostatic carcinoma</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>November 18</u> , 19 <u>82</u> , to <u>December 16</u> , 19 <u>82</u> , that <u>X</u> (we) lost saw the deceased alive on <u>December 16</u> , 19 <u>82</u> , and that in <u>(X)</u> (our) opinion death occurred on the date and hour and from the causes stated above <u>X</u> (we) (did) <u>not</u> view the body after death.							
22b. SIGNATURE <u>D. F. Hughes M.D.</u>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 12/16/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) S. L. HUGHES M.D.				22e. ADDRESS 3900 Loch Raven Blvd. Balto. Md 21218			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-21-82		23c. NAME OF CEMETERY OR CREMATORY Arbutus Memorial		23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Md	
24. FUNERAL DIRECTOR NAME Joseph L. Russ 22224 North Ave.				25a. DATE REC'D. BY REGISTRAR DEC 28 1982		25b. REGISTRAR'S SIGNATURE John J. Carick	



*[Faint, mostly illegible text, possibly bleed-through from the reverse side of the page. Some words like "The", "and", "of", "the", "in", "on", "at", "to", "from", "by", "with", "without", "under", "above", "below", "between", "among", "against", "towards", "into", "out of", "up", "down", "upwards", "downwards", "inward", "outward", "forward", "backward", "sideways", "diagonally", "horizontally", "vertically", "parallel", "perpendicular", "oblique", "acute", "obtuse", "right", "left", "right-hand", "left-hand", "inner", "outer", "innermost", "outermost", "central", "peripheral", "proximal", "distal", "superior", "inferior", "anterior", "posterior", "medial", "lateral", "dorsal", "ventral", "cranial", "caudal", "proximal", "distal", "superior", "inferior", "anterior", "posterior", "medial", "lateral", "dorsal", "ventral", "cranial", "caudal"]*

*[Handwritten notes or markings in the bottom left area, possibly a signature or initials.]*





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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8 2 3 1 9 2 6							
1. FOR STATE REGISTRAR										CERTIFICATE OF DEATH							
1. DECEASED NAME (TYPE OR PRINT)										2a. DATE OF DEATH				2b. HOUR			
JOHN T. STONE										12 25 82				7:30 P.M.			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS							
MALE		CAUCASIAN		11 21 02		80 YRS.		MONTHS DAYS		HOURS MIN.							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH											
South Carolina		U.S.A.				Baltimore City MD.											
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY									
BALTIMORE		GOOD SAMARITAN HOSPITAL				Burner		Beth. Steel									
13a. STATE										13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
Maryland												Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		609 S. Newkirk St. 21224	
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME													
James D. Stone				Virginia B. Greer													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1539 DUE TO, OR AS A CONSEQUENCE OF METASTASIS, CHF. (b) DUE TO, OR AS A CONSEQUENCE OF CA. OF COLON (c) PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
No				213-07-6649		Thomas L. Stone		2801 Plainfield Road Balto., MD. 21222									
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
11/8/82										CA OF COLON		YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)											
				P.M. 19													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that (this hospital) attended the deceased from 12/25/82 to 12/25/82, that (we) last saw the deceased alive on 12/25/82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death)										22b. SIGNATURE		22c. DATE SIGNED					
										MOHAMMED R. SHEBA MD		12/25/82					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)										22e. ADDRESS							
MOHAMMED R. SHEBA										90 Good Sam Hosp.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE											
Burial		12/29/82		Oak Lawn		Baltimore Maryland											
24. FUNERAL DIRECTOR Duda-Ruck, Inc. 7922 Wise Avenue Dundalk, MD. 21222										25a. DATE RECEIVED BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
										DEC 27 1987		John J. Smith					

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U.S. DEPARTMENT OF AGRICULTURE

WASHINGTON, D.C.

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STATE

DATE

TO THE DIRECTOR

NAME

FROM THE

SUBJECT

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BY

FOR

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NOTE

REFERENCE

ENCLOSURE

REMARKS

APPROVED

SPECIAL AGENT IN CHARGE

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15a-c per phone 12/30/82 STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 2 3 1 9 2 7

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH KNOWN ESTI- MATED		<input checked="" type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR		2b. HOUR M			
Donald		Strickland						12		15		19 82			
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7c. DATE PRONOUNCED DEAD		2d. HOUR M			
male	Col v	7-15-1938		44 YRS						12		15 19 82			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH									
S.C.		U.S.A.				Baltimore City,									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY									
Baltimore		2954 Mosher Street		Truck Driver		Trucking									
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS							
Maryland		Baltimore						475. St. N.W. Wash. D.C.							
14. FATHER'S NAME		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST					
Eddie		Mason				Vera		Gray		Ray					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT		ADDRESS									
NO		849-56-2913		Mrs. Dorothy Strickland		2867a.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 5770 IMMEDIATE CAUSE (a) Acute pancreatitis and fatty liver DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .															
ACTUAL SIGNATURE				TITLE (SPECIFY) M.D. Deputy Chief				DATE SIGNED 12/15/82							
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS											
Thomas D. Smith, M.D.				III Penn St. Balto., MD											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN COUNTY			
Burial				12-20-82				Mt. Zion Cem.				Lanham Md.			
24. FUNERAL DIRECTOR NAME				ADDRESS				25a. DATE RECEIVED BY REGISTRAR				25b. REGISTRAR'S SIGNATURE			
Joseph H. Russ				2222 W. North Ave.				DEC 28 1982				John J. Carver			

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

RECEIVED  
JAN 10 1910



DATE OF 1-10-10  
10.10

RECEIVED  
JAN 10 1910  
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JAN 10 1910  
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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 3 1 9 2 8

1 - FOR  
STATE  
REGISTRAR

REG. NO.

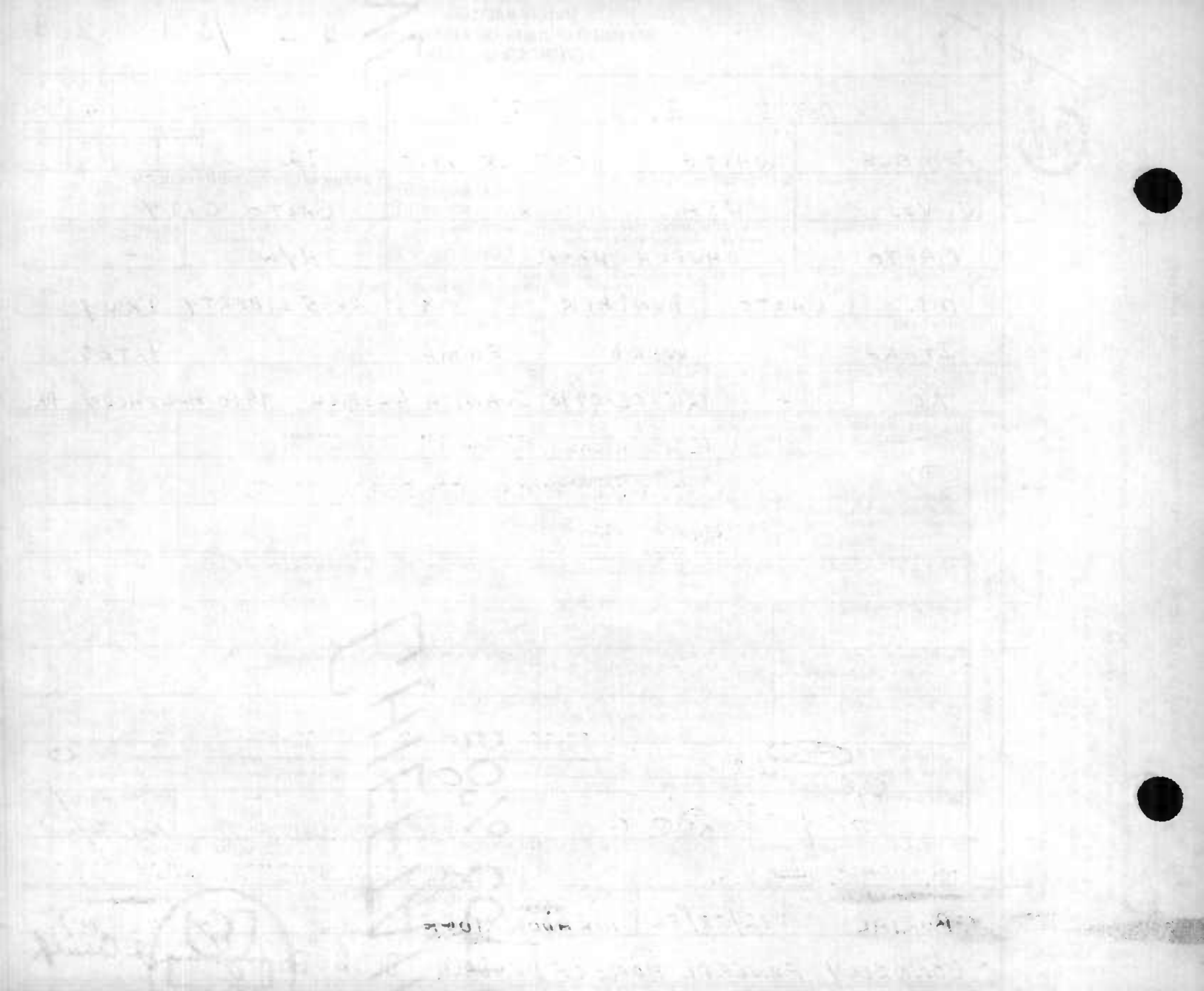
1. DECEASED NAME (TYPE OR PRINT) DOROTHIA E. STRICKLER			2a. DATE OF DEATH MONTH DAY YEAR 12-23-82		2b. HOUR 3.30pm
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR OCT 28 1910	6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) W. VA.	7b. CITIZEN OF WHAT COUNTRY? USA.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH BALTO CITY MD.		
10. CITY OR TOWN OF DEATH BALTO	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CHURCH HOSP.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) H/W	12b. KIND OF BUSINESS OR INDUSTRY -	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE MD. COUNTY BALTO CITY OR TOWN DUNDALK			13b. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13c. STREET ADDRESS 2635 LIBERTY PKWY	
14. FATHER'S NAME FIRST MIDDLE LAST ITHRA WARD		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST EMMA YATES			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) -		17. INFORMANT ADDRESS JUANITA GASPICH 7910 HAWTHORN DR.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 4100 IMMEDIATE CAUSE (a) ACUTE INFERIOR MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) HYPERTENSION					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 12-16 82 12-23- 82	
22a. I certify that (I) (This hospital) attended the deceased from 12-23-82, to 12-23-82, that (I) we most saw the deceased alive on 12-23-82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) we (did) (did not) view the body after death.					
22b. SIGNATURE Steph S. Dang		DEGREE		22c. DATE SIGNED 12/23/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. SINGH S. DANG M.D.		22e. ADDRESS CHURCH HOSPITAL CORPORATION 100 N. BROADWAY BALTIMORE, MARYLAND 21231			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 12/28/82	23c. NAME OF CEMETERY OR CREMATORY MEADOWRIDGE		23d. LOCATION CITY OR TOWN COUNTY STATE BALTO MD.	
24. FUNERAL DIRECTOR NAME X CONNELLY FUNERAL HOME OF DUNDALK		ADDRESS DUNDALK		25a. DATE REC'D. BY REGISTRAR DEC 29 1982	25b. REGISTRAR'S SIGNATURE John J. [Signature]

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1. FOR STATE REGISTRAR		8 2 3 1 9 2 9		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Eli STRONG</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>December 13, 1982</b>		2b. HOUR <b>9:25p M</b>
3. SEX <b>Male</b>	4. RACE <b>Black</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Sept. 23, 1903</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>79 Years YRS.</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Unknown</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City MD.</b>	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Maryland General Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Unknown</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Unknown</b>
13a. STATE <b>MD</b>		13b. COUNTY <b>Baltimore</b>	13c. CITY OR TOWN <b>Baltimore</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <b>501 W. Franklin Street</b>
14. FATHER'S NAME FIRST MIDDLE LAST <b>Unknown</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Unknown</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Unknown</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>434-09-7293</b>		17. INFORMANT ADDRESS <b>Medical Records Department Maryland Gen'l Hospital, 827 Linden Ave.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> <b>4911</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b>Purulent Tracheo-bronchitis</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <b>Severe Chronic obstructive Lung disease.</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>December 10, 19 82</b> to <b>December 13, 19 82</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>December 13, 19 82</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>K. Trent M.D.</b>				22c. DATE SIGNED <b>12/17/82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Karen Trent, M.D.</b>				22e. ADDRESS <b>c/o Maryland General Hospital</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Removal</b>		23b. DATE <b>12/17/82</b>	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE
24. FUNERAL DIRECTOR NAME <b>Anatomy Board</b>		ADDRESS <b>Balto., Md.</b>		25a. DATE RECD BY REGISTRAR <b>DEC 20 1982</b>	
25b. REGISTRAR'S SIGNATURE <b>John J. Connel</b>					



RECEIVED  
FEBRUARY 11 1952  
U.S. DEPARTMENT OF HEALTH  
WASHINGTON, D.C.

9-10

December 12, 1951

TIME

511

Black  
2501 V. Franklin Street  
Washington, D.C.  
201 V. Franklin Street  
Washington, D.C.  
201 V. Franklin Street  
Washington, D.C.

Medical Records Department  
1500-01-3551 Maryland San. & H. Admin. Serv.

Patulent Bronchopneumonia

Severe Chronic obstructive Lung disease.

X

December 12, 1951

December 10, 1951

December 11, 1951

RECEIVED

X

U.S. Department of Health

Water, Trent, H.D.

RECEIVED

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552

8-17-51

RECEIVED

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbonpages. Pages 1 and 2 should be filed within 2 working days of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by telephone.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8	2	3	1	9	3	0																							
1. FOR STATE REGISTRAR										REG. NO.																													
1. DECEASED NAME (TYPE OR PRINT)					FIRST <b>HELEN</b>					MIDDLE <b>STUART</b>					LAST <b>STUART</b>					2a. DATE OF DEATH		MONTH <b>12</b>		DAY <b>18</b>		YEAR <b>1982</b>		2b. HOUR <b>M</b>											
3. SEX <b>FEMALE</b>			4. RACE <b>CAUCASIAN</b>			5. DATE OF BIRTH			MONTH <b>10</b>			DAY <b>31</b>			YEAR <b>1884</b>			6. AGE (IN YEARS LAST BIRTHDAY)			YRS. <b>98</b>			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.													
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b>										MD.																				
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>					11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>PIMLICO MANOR NURSING HOME</b>										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>retired</b>					12b. KIND OF BUSINESS OR INDUSTRY																			
13a. STATE <b>MD.</b>					13b. COUNTY <b>Balt. C. Co.</b>					13c. CITY OR TOWN <b>Baltimore</b>					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					13e. STREET ADDRESS <b>2525 W. Belvedere</b>																			
14. FATHER'S NAME					FIRST <b>Md.</b>					MIDDLE <b></b>					LAST <b></b>					15. MOTHER'S MAIDEN NAME					FIRST <b></b>					MIDDLE <b></b>					LAST <b></b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b. SOCIAL SECURITY NO.					17. INFORMANT										ADDRESS																			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>7070</b> IMMEDIATE CAUSE (a) <b>SEPSIS</b>																				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>DAYS</b>																			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.																				DUE TO, OR AS A CONSEQUENCE OF (b) <b>DECUBITUS</b> <b>ULCER</b>					DAYS														
DUE TO, OR AS A CONSEQUENCE OF (c)																																							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																																							
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>																			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)					21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>					21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)																													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK					21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)					21f. LOCATION STREET CITY OR TOWN COUNTY STATE																													
22a. I certify that (I) (this hospital) attended the deceased from <b>15 DECEMBER 1982</b> to <b>18 DECEMBER 1982</b> , that (I) (we) last saw the deceased alive on <b>18 DECEMBER 1982</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.																																							
22b. SIGNATURE <b>Arthur M. Weiss</b>										DEGREE <b>MD</b>										22c. DATE SIGNED <b>12-18-82</b>																			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ARTHUR M. WEISS MD</b>										22e. ADDRESS <b>3640 FORBES LANE BALD MD 21215</b>																													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>					23b. DATE <b>1/6/83</b>					23c. NAME OF CEMETERY OR CREMATORY <b>Greenwood</b>					23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore MD</b>																								
24. FUNERAL DIRECTOR NAME <b>IRVING P. CARROLL</b>										25a. DATE REC'D. BY REGISTRAR <b>JAN 4 1983</b>										25b. REGISTRAR'S SIGNATURE <b>John J. Carroll</b>																			

*[Faint, mostly illegible handwriting on lined paper. Some words like "The", "and", "of" are visible.]*



*[Vertical text on the right margin, possibly a page number or reference.]*

*[Faint text at the bottom of the page, possibly a signature or date.]*

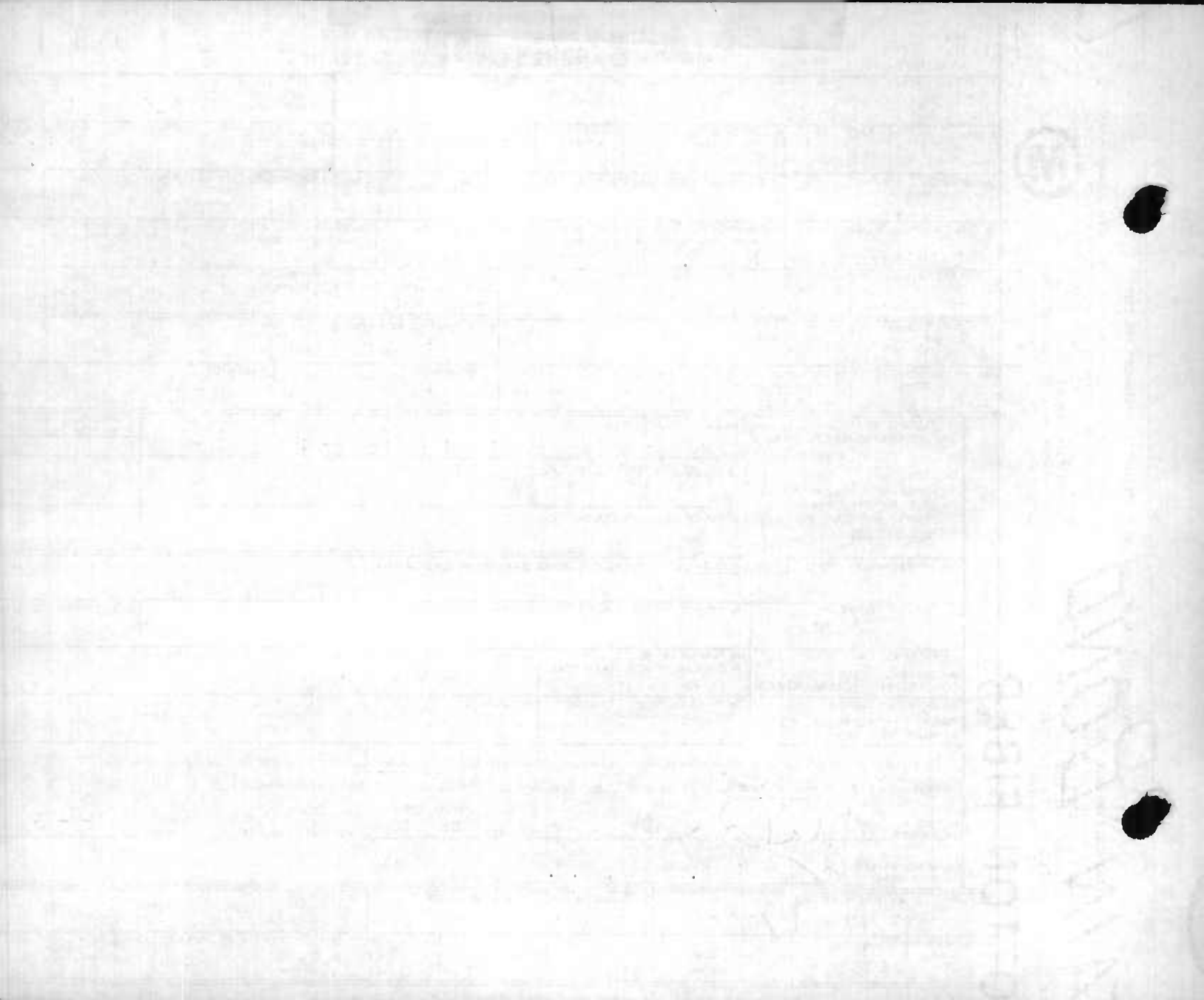
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITH PAGES 3 AND 4 AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR  
1- STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		<input type="checkbox"/> MONTH		DAY		YEAR		2b. HOUR	
Hargis						Stubbs		12		29		19		82		M	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR	
Male	Black	1 17 19		63 YRS.		MONTHS		DAYS		12		30		19		82	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH									
Md.		USA						Baltimore City,								MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY											
Baltimore		1615 E. 25th Street															
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS									
Md.				Balto.				1615 E. 25th St.								21218	
14. FATHER'S NAME		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME		MIDDLE		LAST							
Unkn						UnKn											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS											
Yes		WWII		212-16-1342		Lillian Stubbs		1615 E. 25th St.									
10. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive Arteriosclerotic Cardiovascular</u> Disease Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last.		(b) _____ DUE TO, OR AS A CONSEQUENCE OF		(c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
4029																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE							
22a. I certify that I took charge of the remains described above, held on		Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion		death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE		TITLE (SPECIFY)		MEDICAL EXAMINER		DATE SIGNED		1-4-83									
EXAMINER'S NAME (TYPE OR PRINT)		Dennis F. Smyth, M.D.		ADDRESS		111 Penn Street											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		COUNTY		STATE							
Burial		1/5/82		Md. Vet. Cem.		Crownsville, Md.											
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE											
Wm C March F/H		1101 E. North Ave.		JAN 6 1983		John J. Larnick											



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 3 1 9 3 2

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Essie C. Suber			2a. DATE OF DEATH MONTH DAY YEAR 12 6 82			2b. HOUR M M	
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 11 25 1880		6. AGE (IN YEARS LAST BIRTHDAY) 102	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) S. Carolina		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3806 Rexmere Road				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Thornton Chick		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Vinnie					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 247-88-1584		17. INFORMANT ADDRESS Essie S. Brooks 3806 Rexmere Rd.			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART I. DEATH WAS CAUSED BY:

0090

IMMEDIATE CAUSE (a) acute myocardial infarction

DUE TO, OR AS A CONSEQUENCE OF (b) recent viral gastroenteritis

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (c) \_\_\_\_\_

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 7, 19 81, to 12, 19 82, that (I) (we) last saw the deceased alive on 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>John H. Eppke</i>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/7/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John H. Eppke, MD				22e. ADDRESS UMH.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 12/10/82		23c. NAME OF CEMETERY OR CREMATORY Church Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Santuck, S.C.	
24. FUNERAL DIRECTOR NAME ADDRESS Wm. C. March F/H Inc. 1101 E. North Ave.				25a. DATE REC'D. BY REGISTRAR DEC 7 - 1982		25b. REGISTRAR'S SIGNATURE <i>John J. Chief</i>	

MEDICAL CERTIFICATION

DEC 7 - 1941

Handwritten notes and signatures at the bottom of the page, including a signature that appears to be "John G. ...".





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the death certificate file with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										
CERTIFICATE OF DEATH										
FOR 1 - STATE REGISTRAR					REG. NO.					
4. DECEASED NAME (TYPE OR PRINT) <b>BEATRICE SULLIVAN</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>12 9 82</b> 2b. HOUR <b>11:20 P M</b>					
3. SEX <b>Female</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>12 28 24</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>57</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Raleigh, N. C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.				
10. CITY OR TOWN OF DEATH <b>BALTO. CITY</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>THE UNION MEMORIAL HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>					13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>N/A</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>N/A</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>		16b. SOCIAL SECURITY NO. <b>215-24-1209</b>		17. INFORMANT ADDRESS <b>Albert Sullivan 2329 Aiken St.</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebrovascular Accident</b> <b>2041</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Thrombocytopenia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <b>Chronic Lymphocytic Leukemia</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Diabetes Mellitus</b>										
19a. DATE OF OPERATION <b>None</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <b>Nov 11</b> , 19 <b>82</b> , to <b>Dec 9</b> , 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>Dec 9</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Michael Horrocks M.D. / Robert A. Miller M.D.</b>					DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>12/7/82</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Robert A. Miller M.D.</b>					22e. ADDRESS <b>Union Mem. Hospital Baltimore</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>12/15/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Pikesville Md.</b>				
24. FUNERAL DIRECTOR NAME ADDRESS <b>Wm. C. March F/H Inc. 1101 E. North Avenue</b>					25a. DATE REC'D. BY REGISTRAR <b>DEC 13 1982</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Carver</b>			

1957 11 28 P 21



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8	2	3	1	9	3	4
1. FOR STATE REGISTRAR										REG. NO.						
1. DECEASED NAME (TYPE OR PRINT) <b>PAUL ANDREW SULLIVAN</b>										2a. DATE OF DEATH MONTH DAY YEAR <b>December 17, 1982</b>				2b. HOUR M		
3. SEX <b>Male</b>			4. RACE <b>White</b>			5. DATE OF BIRTH MONTH DAY YEAR <b>Dec. 19, 1900</b>			6. AGE (IN YEARS LAST BIRTHDAY) <b>81</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Penna.</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.							
10. CITY OR TOWN OF DEATH <b>Baltimore</b>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>2409 Brambelton Rd. (Residence)</b>						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Lawyer</b>			12b. KIND OF BUSINESS OR INDUSTRY				
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)																
13a. STATE <b>Maryland</b>			13b. COUNTY		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>2409 Brambelton Rd. 21209</b>							
14. FATHER'S NAME FIRST MIDDLE LAST <b>Andrew A. Sullivan</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Teresa E. Conroy</b>											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>					16b. SOCIAL SECURITY NO. <b>213-38-8290</b>		17. INFORMANT ADDRESS <b>Mary E. Sullivan 2409 Brambelton Rd. 21209</b>									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: <b>4100 Myocardial Infarction, acute</b> IMMEDIATE CAUSE (a) <b>4100</b> DUE TO, OR AS A CONSEQUENCE OF - Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>4100</b> DUE TO, OR AS A CONSEQUENCE OF - (c) <b>4100</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 minutes</b>						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <b>Chronic Brain Syndrome</b>																
19a. DATE OF OPERATION <b>-</b>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>-</b>					20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) <b>-</b>										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <b>-</b>			21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>- Baltimore Maryland</b>										
22a. I certify that (I) (this hospital) attended the deceased from <b>Mar 6 1982</b> , to <b>Dec 19 1982</b> , that (I) (we) last saw the deceased alive on <b>Mar 6 1982</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.																
22b. SIGNATURE <b>Robert Levy, M.D.</b>			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <b>12/2/82</b>							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Dr. Robert Levy M.D.</b>					22e. ADDRESS <b>Medical Arts Building Baltimore, Md.</b>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>Dec 21 1982</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge Cemetery</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Maryland</b>								
24. FUNERAL DIRECTOR NAME ADDRESS <b>Leonard J. Ruck, Inc. Baltimore, Maryland</b>					25a. DATE REC'D. BY REGISTRAR <b>DEC 21 1982</b>			25b. REGISTRAR'S SIGNATURE <b>Joan J. Conroy</b>								



Item #5&amp;6 Film G575 1/3/83 rc

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 3 1 9 3 5

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>FELICIA R. SWANN</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>12 11 82</b>			2b. HOUR <b>8:38P<sup>M</sup></b>				
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>8 15 1925</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>54 57</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.				
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>St. Agnes Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Claims Authorizer</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Soc. Sec. U.S. Govt.</b>		
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Arbutus</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>5523 Dolores Avenue 21227</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Stephen Betz</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Sophia Trochi</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>			16b. SOCIAL SECURITY NO. <b>220-14-2711</b>		17. INFORMANT ADDRESS <b>Philip M. Swann 2903 Georgia Avenue 21227</b>					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4140 Cardiac Arrest</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ASHD</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b> <b>unknown</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)			

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>12/11</b> , 19 <b>82</b> , to <b>12/11</b> , 19 <b>82</b> , that (I) (we) lost <b>12/11</b> 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (didn't) view the body after death.							
22b. SIGNATURE <b>James Nolan</b>				DEGREE <b>MD</b>		22c. DATE SIGNED <b>12/13/82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>James Nolan, MD.</b>				22e. ADDRESS <b>1 Mallow Hill Road</b>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>12/15/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Sacred Heart of Mary</b>		23d. LOCATION COUNTY STATE <b>Dundalk Balto. Maryland</b>	
24. FUNERAL DIRECTOR NAME <b>Hubbard Funeral Home, Inc. 4107 Wilkens Ave.</b>				25a. DECEASED BY REGISTRAR <b>DEC 15 1982</b>		25b. REGISTRAR'S SIGNATURE <b>John J. [Signature]</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, and may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

UNITED STATES DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY

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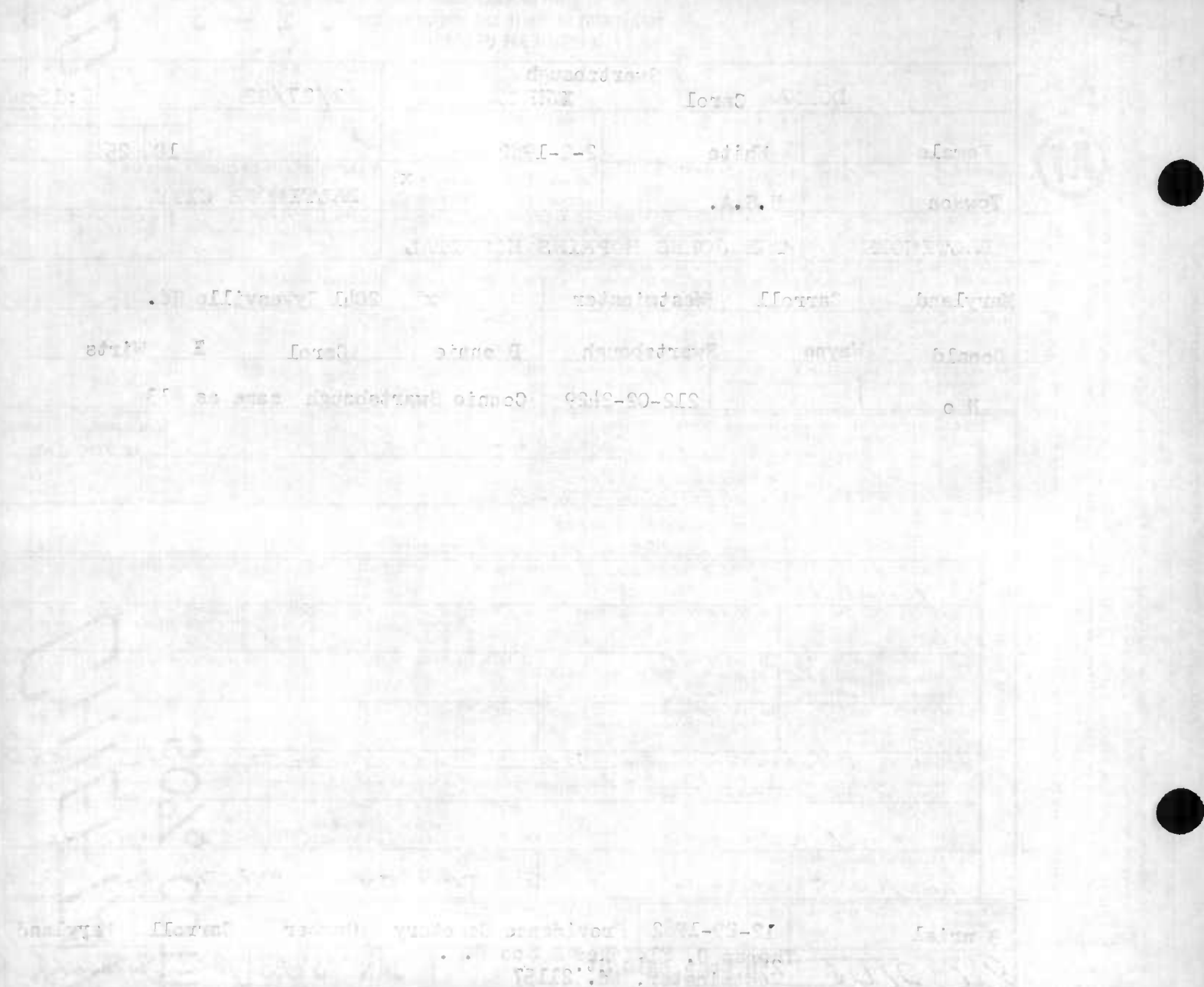
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 10 days of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified!

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 3 1 9 3 6 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>DONNA Carol Swartzbaugh WIRTS</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>12/27/82</b>			2b. HOUR <b>5:15pm</b>			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>2-2-1982</b>		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN. <b>YRS. 10 25</b>		7b. HOUR			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Towson</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.					
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>THE JOHNS HOPKINS HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Carroll</b>		13c. CITY OR TOWN <b>Westminster</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>2041 Sykesville Rd.</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Donald Wayne Swartzbaugh</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Bonnie Carol Wirts</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>				16b. SOCIAL SECURITY NO. <b>212-02-2429</b>		17. INFORMANT ADDRESS <b>Connie Swartsbaugh same as #13</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIORESPIRATORY ARREST</b> <b>7707</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>RESPIRATORY FAILURE</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Bronchopulmonary Dysplasia</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10 months</b>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Failure to Thrive</b>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <b>7/10</b> , 19 <b>82</b> , to <b>12/27</b> , 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>12/27</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Andrea Zuckerman</b>					DEGREE <b>M.D.</b>			22c. DATE SIGNED <b>12/27/82</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ANDREA ZUCKERMAN</b>					22e. ADDRESS <b>THE JOHNS HOPKINS HOSPITAL, BALTIMORE, MD</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>12-29-1982</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Providence Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Gamber Carroll Maryland</b>				
24. FUNERAL DIRECTOR NAME <b>Thomas D. Fletcher &amp; Son F.H.</b>					25a. DATE REC'D. BY REGISTRAR <b>JAN 5 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Connelley</b>				

BP





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 3 1 9 3 7

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Theresa Szczepaniak</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>12/26/82</i>			2b. HOUR <i>5:09<sup>PM</sup></i>	
3. SEX <i>female</i>		4. RACE <i>Caucasian</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>06 10 15</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>67</i> YRS.	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>BALTO CITY</i> MD.	
10. CITY OR TOWN OF DEATH <i>Baltimore</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>CHURCH HOSPITAL NOSPICE PROG.</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE <i>MD</i>		13c. COUNTY <i>Baltimore</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <i>507 S. MILTON ST BALTO MD</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Garezynski</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Frances</i>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <i>No</i>			
16b. SOCIAL SECURITY NO. <i>212-10-5406</i>		17. INFORMANT ADDRESS <i>George Barker 507 S. Milton Ave</i>					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

1539

IMMEDIATE CAUSE (a) *Carcinomatosis*

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

(b) *Carcinoma of rt. colon*

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

MEDICAL CERTIFICATION

19a. DATE OF OPERATION <i>11-26-82</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Intestinal obstruction 2° to Tumor</i>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>Mar 13</i> , 19 <i>82</i> , to <i>Dec 26</i> , 19 <i>82</i> , that (I) (we) last saw the deceased alive on <i>Dec 26</i> , 19 <i>82</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>12 - S. Lee, M.D.</i>		DEGREE <i>HOA S. LEE</i>		ATTENDING <input checked="" type="checkbox"/> MEDICAL <input type="checkbox"/> STAFF <input type="checkbox"/> PHYSICIAN DIRECTOR PHYSICIAN		22c. DATE SIGNED <i>12-26-82</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>HOA S. LEE</i>		22e. ADDRESS <i>1134 York Rd. Lutherville, Md. 21093</i>					

23a. BURIAL, CREMATION, REMOVAL (CHECK) <i>Burial</i>		23b. DATE <i>12.30.82</i>		23c. NAME OF CEMETERY OR CREMATORY <i>St. Stanislaus</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Baltimore City Md.</i>	
24. FUNERAL DIRECTOR NAME <i>Raymond Kaczorowski</i>				ADDRESS <i>2005 Hubbard</i>		25a. DATE REC'D BY REGISTRAR <i>DEC 29 1982</i>	
						25b. REGISTRAR'S SIGNATURE <i>John J. Conish</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

OFFICE OF THE ATTORNEY GENERAL

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

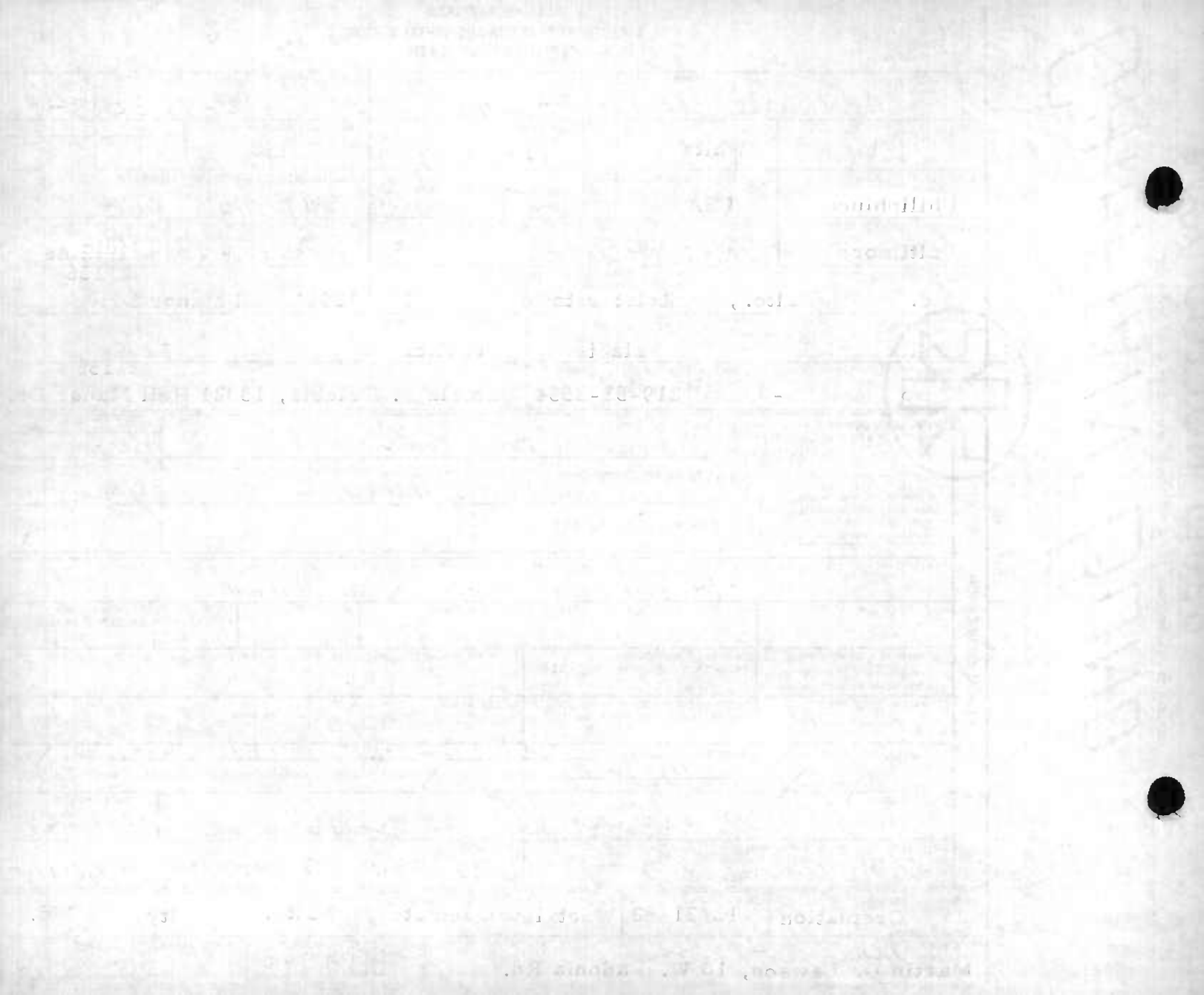
**RETURN TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed within 27 hours of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT:** If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>REYNARDO LOPEZ TALABIS</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>12-15-82</b>		2b. HOUR <b>3:50 PM</b>	
3. SEX <b>M</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>12-11-35</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Philippines</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>49</b> YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SINAE HOSPITAL</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.	
13a. STATE <b>Md.</b>		13b. CITY OR TOWN <b>Balto.,</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>PHYSICIAN</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Felix Talabis</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Purita Lopez</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Medicine</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>219-52-2534</b>		13c. STREET ADDRESS <b>13021 Heil Manor Drive</b>	
17. INFORMANT <b>Pamela B. Talabis, 13021 Heil Manor Dr.</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: <b>4149 Ventricular Arrhythmia</b> IMMEDIATE CAUSE (a) <b>Ventricular Arrhythmia</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Coronary Artery Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Seconds</b> <b>years.</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <b>Hypertensive Cardiovascular Disease</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>12/11/82</b> to <b>12/15/82</b> , that (I) (we) last saw the deceased alive on <b>11/19/82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.					
22b. SIGNATURE <b>B. A. Cochran</b> DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>12-15-82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>B. A. Cochran, M.D.</b>				22e. ADDRESS <b>6506 PARK HEIGHTS AVE, BALD, 21215</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>12/21/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Westview Crematory</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Balto. City Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>DEC 17 1982</b>			
24. FUNERAL DIRECTOR NAME <b>Martin D. Lawson</b>		ADDRESS <b>10 W. Padonia Rd.</b>		25b. REGISTRAR'S SIGNATURE <b>Jo Ann J. Connel</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Populations be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use at the burial-transit permit. Their please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical records and the attending physician should be consulted.

1. FOR  
STATE  
REGISTRAR
 STATE OF MARYLAND  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 CERTIFICATE OF DEATH

8 2 3 1 9 3 9

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>NANCY LEE TATE</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>12-2-82</b>			2b. HOUR <b>11:00 A</b>				
3. SEX <b>F</b>		4. RACE <b>C I</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>July 27, 1903</b>			6. AGE (IN YEARS LAST BIRTHDAY) <b>78</b> YRS.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.				
10. CITY OR TOWN OF DEATH <b>Baltimore Md</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>2611 Park Height Terrace</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Domestic</b>		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Virginia</b>		13b. COUNTY <b>Louisa</b>		13c. CITY OR TOWN <b>Gordonsville</b>		13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		13e. STREET ADDRESS <b>Rt. 2 Box 313</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>William Verdier</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Irene Young</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. <b>230-80-4486</b>		17. INFORMANT ADDRESS <b>Ella Mae Tate Wells</b>						
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY <b>4049 ACUTE MYOCARDIAL INFARCT.</b> IMMEDIATE CAUSE (a) <b>ACUTE MYOCARDIAL INFARCT</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>HEART DISEASE</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>HEART DISEASE</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <b>3/30/81</b> 19 to <b>12/2/82</b> 19, that (I) (we) last saw the deceased alive on <b>11/30/82</b> 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>J. Shorofsky, M.D.</b>						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>12/2/82</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>SHOROFSKY</b>						22e. ADDRESS <b>4734 PARK HEIGHTS AVE 21215</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>12-5-82</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Family Cemetery</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Gordonsville Louisa Virginia</b>	
24. FUNERAL DIRECTOR NAME <b>Mr. Lee C #21</b> ADDRESS						25a. DATE REC'D. BY REGISTRAR <b>DEC 7 1982</b>				
25b. DATE REC'D. BY REGISTRAR <b>DEC 7 1982</b>										



July 27, 1963

Baltimore City

x

T. J. A.

Virginia

2611 Jack Rabbit Lane, Baltimore, Md.

Mr. J. Edgar Hoover, U.S. Dept. of Justice, Washington, D.C.

Dear Mr. Hoover:

Enclosed for you are two copies of

no

Enclosed for you are two copies of

W. J. A.

Enclosed for you are two copies of



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 3 1 9 4 0

FOR  
1 - STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Mary c. Tate</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>December 23, 1982</i>		2b. HOUR M
3. SEX <i>Female</i>	4. RACE <i>White</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>May 15, 1910</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>72</i> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>	7b. CITIZEN OF WHAT COUNTRY? <i>United States</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City</i> MD.	
10. CITY OR TOWN OF DEATH <i>Baltimore</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>3202 Elliott St. (21224)</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Machine operator</i>	12b. KIND OF BUSINESS OR INDUSTRY <i>Distillery</i>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE <i>Maryland</i>	13b. COUNTY <i>-</i>	13c. CITY OR TOWN <i>Baltimore</i>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <i>3202 Elliott St. (21224)</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Frank - Swiec</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Mary - Kluza</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <i>NO -</i>		16b. SOCIAL SECURITY NO. <i>217-20-8750</i>		17. INFORMANT ADDRESS <i>Julia Tylisz 1117 S. East Ave. (21224)</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardio Pulmonary Arrest</i> <i>1749</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Metastatic Breast Carcinoma</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>10</i>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>July 19 80</i> to <i>Oct 19 82</i> , that (I) (we) lost saw the deceased alive on <i>Oct 19 82</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.					
22b. SIGNATURE <i>Myo Thang</i>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>12/23/82</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>MYO THANG</i>		22e. ADDRESS <i>9601 FRANKLIN SQ-DR, BALTO, MD 21237</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>Dec. 27, 1982</i>	23c. NAME OF CEMETERY OR CREMATORY <i>St. Stanislaus Cem.</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Baltimore - Maryland</i>
24. FUNERAL DIRECTOR NAME ADDRESS <i>Lilly &amp; Zeiler Inc. 700 S. Conkling St.</i>			25a. DATE REC'D. BY REGISTRAR <i>DEC 28 1982</i>		25b. REGISTRAR'S SIGNATURE <i>John G. Smith</i>

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										
1. FOR STATE REGISTRAR					8 2 3 1 9 4 1					
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH					
BABY GIRL TAYLOR					9 27 82 3 P M					
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR		
FEMALE		BLACK		9 24 82		YRS. 3		MONTHS 3		
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7c. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				
MARYLAND		UNITED STATES				BALTIMORE CITY MD.				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
BALTIMORE		ST AGNES HOSPITAL				NA		NA		
13a. STATE					13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
MARYLAND							BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME					
FIRST MIDDLE LAST					FIRST MIDDLE LAST					
					KIM TAYLOR					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b. SOCIAL SECURITY NO.		17. INFORMANT			
NA					NA		KIM A. TAYLOR			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										
PART I. DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a) HEART FAILURE										
7651 DUE TO, OR AS A CONSEQUENCE OF (b) PREMATURE AND NEONATAL ASPHYXIA										
DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
NONE						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED		(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
		HOUR A.M. MONTH DAY YEAR		P.M. 19						
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION						
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		STREET		CITY OR TOWN		COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 9 SEPT 24 19 82, to SEPT 27 19 82, that (I) (we) lost saw the deceased alive on SEPT 27 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE					DEGREE			22c. DATE SIGNED		
Mark D Harris MD					ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			10/28/82		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS					
MARK D. HARRIS MD					500 NOTTINGHAM RD BALTO, MD					
23a. BURIAL, CREMATION, REMOVAL		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		23e. DATE REC'D. BY REGISTRAR		
BURIAL		1/18/83		NEW CATHEDRAL CEMETERY		BALTIMORE		JAN 19 1983		
24. FUNERAL DIRECTOR					25a. REGISTRAR'S SIGNATURE					
WITZKE P A 1630 EDMONDSON AVENUE, CATONSVILLE, MD. 21228					John J. Connel					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked at item 18 shows any injury, or other traumatic event, the medical examiner must be notified about it.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 3 1 9 4 2			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>BABY/GIRL TAYLOR</b>				2a. DATE OF DEATH MONTH <b>12</b> DAY <b>4</b> YEAR <b>82</b>		2b. HOUR <b>3 15</b> P.M.	
3. SEX <b>FEMALE</b>		4. RACE <b>BLACK</b>		5. DATE OF BIRTH MONTH <b>DEC</b> DAY <b>04</b> YEAR <b>1982</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS <b>0</b> MONTHS <b>8</b> DAYS <b>8</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.	
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>JOHNS HOPKINS HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>MARYLAND</b>		13b. CITY OR TOWN <b>BALTIMORE</b>		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS <b>1307 WILCOX ST</b>	
14. FATHER'S NAME FIRST <b>RODNEY</b> MIDDLE <b>FRAZIER</b> LAST <b>TAYLOR</b>		15. MOTHER'S MAIDEN NAME FIRST <b>JOANN</b> MIDDLE <b>TAYLOR</b> LAST <b>TAYLOR</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PREMATURE</b> <b>7651</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>PREMATURE</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>PREMATURE</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>NO</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from <b>DEC-4</b> , 19 <b>82</b> , to <b>DEC-4</b> , 19 <b>82</b> , that (1) (we) last saw the deceased alive on <b>Dec-4</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>V. Narayanan M.D.</b>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>12/4/82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>V. NARAYANAN M.D.</b>				22e. ADDRESS <b>DEPT. OF PEDIATRICS, JOHNS HOPKINS HOSP.</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>CREMATION</b>		23b. DATE <b>DEC 08, 1982</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Johns Hopkins</b>		23d. LOCATION CITY OR TOWN <b>Baltimore</b> COUNTY <b>Md</b> STATE <b>Md</b>	
24. FUNERAL DIRECTOR NAME ADDRESS				25a. DATE REC'D. BY REGISTRAR <b>DEC 21 1982</b> REGISTRAR'S SIGNATURE <b>John J. Gough</b>			

TECHNICAL FIELD

## 5.1 INTRODUCTION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 10 days of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical certification completed.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										
1. FOR STATE REGISTRAR					8 2 3 1 9 4 3					
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH					
Edward - L. Taylor					12/13/82					
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		2b. HOUR		
Male		Caucasian		12/3/1912		70 YRS.		353 P.M.		
7. BIRTHPLACE (STATE OR FOREIGN)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				
Ind. USA		USA				Balt. City MD.				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
Balt. Md.		University Hosp				Mechanics		Test Engaged		
13a. STATE					13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
Md					Balt		Balt		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME					
Daughter					Unknown					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b. SOCIAL SECURITY NO.		17. INFORMANT			
NO					416 52 0003		Mary Wagner			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
1991 IMMEDIATE CAUSE (a) Resp. Arrest										
DUE TO, OR AS A CONSEQUENCE OF										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					(b) Malignant Carcinoma					
DUE TO, OR AS A CONSEQUENCE OF										
(c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
			P.M. 19							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION				
						CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 12/10, 1982, to 12/13, 1982, that (I) (we) lost saw the deceased alive on 12/13, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE					DEGREE		22c. DATE SIGNED			
H. H. H. M.D.							12/13/82			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS					
Henry Ohlener					Univ. Hospital					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION			
Burial			12-16-1982		Cedar Hill Cem.		Baltimore Co. Md.			
24. FUNERAL DIRECTOR NAME					25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
John J. Cowan & Son, Inc. 901 Hollins St. Baltimore, Md. 21223					DEC 16 1982		John J. Cowan			



30

RECEIVED  
FEB 10 1960



CHILLY

60% 60%

DEC 10 1960

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 3 1 9 4 4

1. FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <i>Frances R. Taylor</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>December 20, 1982</i>		2b. HOUR M <i></i>
3. SEX <i>Female</i>	4. RACE <i>White</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>8/12/1903</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>79</i> YRS.	IF UNDER 1 YEAR MONTHS DAYS <i></i>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Czechoslovakia</i>	7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City</i> MD.	
10. CITY OR TOWN OF DEATH <i>Baltimore</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>5000 Pennington Avenue,</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Domestic</i>
13a. STATE <i>Maryland</i>			13b. COUNTY <i>---</i>	13c. CITY OR TOWN <i>Baltimore</i>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST <i>Ladislav Pazdena</i>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Marie Hallinda</i>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <i>no</i>		16b. SOCIAL SECURITY NO. <i>215-03-2399</i>		17. INFORMANT <i>Glen Burnie, Md. 21067</i> <i>William C. Taylor 221 S. Hammonds Ferry Rd.,</i>	

## 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

*4292*  
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b) *Arteriosclerotic Cardiovascular*

DUE TO, OR AS A CONSEQUENCE OF

(c) *Disease*

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

## PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

① *Senility* ② *Thoracic Aneurysm*

19a. DATE OF OPERATION <i>7/73</i>	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i></i>	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i></i> P.M. <i>19</i>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE <i></i>	
22a. I certify that (I) (this hospital) attended the deceased from <i>July</i> , 19 <i>73</i> , to <i>20-Dec</i> , 19 <i>82</i> , that (I) (we) last saw the deceased alive on <i>25-Sept</i> , 19 <i>82</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <i>Richard E. Fisher</i>	DEGREE	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED <i>21-Dec-82</i>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Dr. Richard E. Fisher, M.D.</i>		22e. ADDRESS <i>4700 Pennington Ave., Baltimore, Md. 21206</i>	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>	23b. DATE <i>12/22/1982</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill Cemetery</i>	23d. LOCATION CITY OR TOWN COUNTY STATE <i>Baltimore, A. A. Co., Md.</i>
24. FUNERAL DIRECTOR NAME <i>McMully Funeral Homes</i>		25a. DATE REC'D. BY REGISTRAR <i>DEC 23 1982</i>	25b. REGISTRAR'S SIGNATURE <i>John J. Smith</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Registrar after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified in advance.

DATE: 11/11/11



Time	Location	Activity	Remarks
08:00	Room 101	Check-in	Arrived on time
08:30	Room 101	Meeting	Discussed project progress
09:00	Room 101	Work	Completed task A
09:30	Room 101	Work	Completed task B
10:00	Room 101	Work	Completed task C
10:30	Room 101	Work	Completed task D
11:00	Room 101	Work	Completed task E
11:30	Room 101	Work	Completed task F
12:00	Room 101	Work	Completed task G
12:30	Room 101	Work	Completed task H
13:00	Room 101	Work	Completed task I
13:30	Room 101	Work	Completed task J
14:00	Room 101	Work	Completed task K
14:30	Room 101	Work	Completed task L
15:00	Room 101	Work	Completed task M
15:30	Room 101	Work	Completed task N
16:00	Room 101	Work	Completed task O
16:30	Room 101	Work	Completed task P
17:00	Room 101	Work	Completed task Q
17:30	Room 101	Work	Completed task R
18:00	Room 101	Work	Completed task S
18:30	Room 101	Work	Completed task T
19:00	Room 101	Work	Completed task U
19:30	Room 101	Work	Completed task V
20:00	Room 101	Work	Completed task W
20:30	Room 101	Work	Completed task X
21:00	Room 101	Work	Completed task Y
21:30	Room 101	Work	Completed task Z

Project Summary: The project was completed successfully on time and within budget. All tasks were completed as planned, and the final report was submitted. The team worked hard and achieved great results. The project was a success and we are proud of the team's performance.

Next Steps: The project has been completed, but there are still some minor tasks that need to be done. These will be completed by the end of the month. The team will continue to work on these tasks and ensure that everything is in order.

Conclusion: The project was a success and we are proud of the team's performance. The team worked hard and achieved great results. The project was a success and we are proud of the team's performance.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM RM-3. RETAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 10-15-77 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST GORDON TAYLOR G.										2a. DATE KNOWN OF DEATH MONTH DAY YEAR 12-25-82		2b. HOUR M			
1. SEX M		4. RACE B		5. DATE OF BIRTH MONTH DAY YEAR 10-25-48		6. AGE (IN YEARS) LAST BIRTHDAY 34 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 12-25-82		7d. HOUR M 4:16 P			
7a. BIRTHPLACE (STATE OR COUNTY) Md				7b. CITIZEN OF WHAT COUNTRY? U.S.A				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD			
11. CITY OR TOWN OF DEATH Baltimore				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3719 Colborne Avenue				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Md				13b. COUNTY Baltimore				13c. CITY OR TOWN Baltimore				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 3719 Colbourne Rd 21229	
14. FATHER'S NAME FIRST MIDDLE LAST John Gordon				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Laura Vennie				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. ?			
17. INFORMANT John Gordon				ADDRESS 3719 Colbourne Rd											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Seizure disorder DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR ? P.M. ? 19 ?				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2) Apparent old injury due to fall							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Unknown				21f. LOCATION STREET CITY OR TOWN COUNTY STATE Unknown Unknown							
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .															
ACTUAL SIGNATURE Margie Breghu				TITLE (SPECIFY) M.D. Assistant				MEDICAL EXAMINER				DATE SIGNED 12-26-82			
EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D.				ADDRESS 111 Penn Street											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 12-30-82				23c. NAME OF CEMETERY OR CREMATORY Mulberry B.C.				23d. LOCATION CITY OR TOWN COUNTY STATE Richmond Co. VA			
24. FUNERAL DIRECTOR NAME Vernon R. Bailey				ADDRESS 1348 N. Calhoun St				25a. DATE REC'D. BY REGISTRAR DEC 29 1982				25b. REGISTRAR'S SIGNATURE John J. Canine			

PATIENT INFORMATION		MEDICAL HISTORY		PHYSICAL EXAMINATION		LABORATORY TESTS		TREATMENT		REMARKS	
1	2	3	4	5	6	7	8	9	10	11	12
[Faint, illegible text and markings throughout the form body]											

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 1 hour after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified and a post-mortem examination must be made.

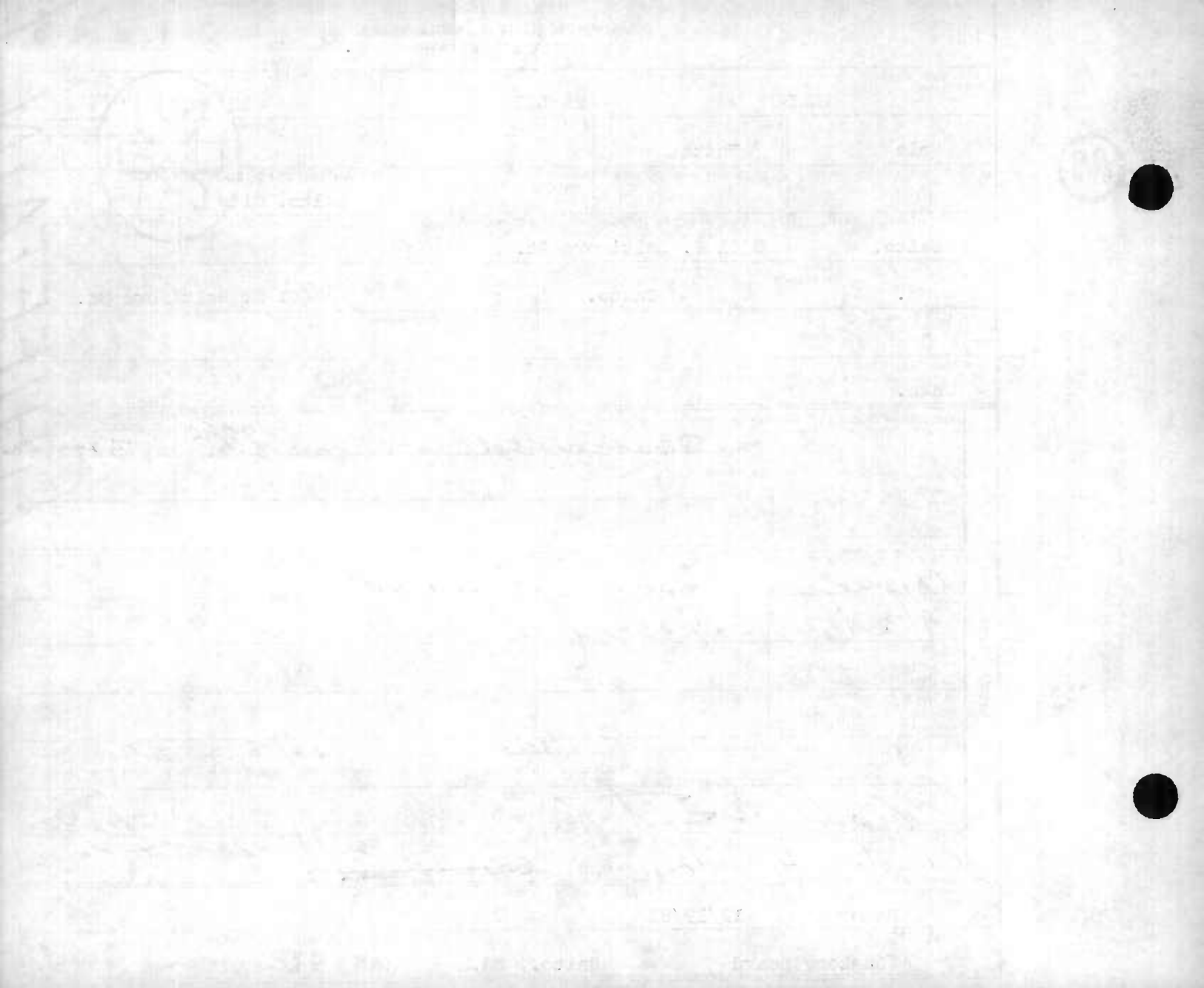
1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 3 1 9 4 6

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>WILLIAM TAYLOR</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>12 19 82</b>			2b. HOUR M <b>M</b>	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY) YEARS MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Balto. City</b>	
10. CITY OR TOWN OF DEATH <b>Balto.</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>3401 E. Baltimore St.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING YEARS)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Md.</b>		13b. COUNTY		13c. CITY OR TOWN <b>Balto.</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS <b>3401 E. Baltimore St.</b>							
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Unkn.</b>			16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Squamous cell carcinoma of the tongue</b> 1419 DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 months</b>							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <b>Chronic pulmonary disease</b>							
19a. DATE OF OPERATION <b>9/30/82</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Cancer of the tongue</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>9/30/82</b> , 19 <b>82</b> , to <b>12/18</b> , 19 <b>82</b> ; that (I) (we) last saw the deceased alive on <b>19</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Charles H. Hightstein</b>		DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>12/28/82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Charles Hightstein</b>		22e. ADDRESS <b>Baltimore City Hosp.</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Removal</b>		23b. DATE <b>12/19/82</b>		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME <b>Anatomy Board</b>				25a. DATE REC'D. BY REGISTRAR <b>JAN 4 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Conish</b>	





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 3 1 9 4 7

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>COYT ALEXANDER TERRY</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>12 16 82</b>		2b. HOUR <b>4:50 P.M.</b>
3. SEX <b>MALE</b>	4. RACE <b>B</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>01 01 12</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>70</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b>		MD.			
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>San Segours Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13. STATE <b>Maryland</b>			13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS <b>910 N. Wheeler Avenue</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Sandy Terry</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Ellen Covington</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>4275</b>		17. INFORMANT ADDRESS <b>Robert Terry 9 N. Wheeler Ave</b>	
18. CAUSE OF DEATH (Enter only one cause per line for 18a, 18b, and 18c.) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coma</b> <b>4275</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Hypoxic encephalopathy</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Cardiac arrest 2° vent. fibrillation</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>CHF 2° ASCVD; chronic renal failure</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) P.M. 19		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>12/06/82</b> to <b>12/16/82</b> , that (I) (we) lost saw the deceased alive on <b>12/16/82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Beltran</b>		DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>12/16/82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JUAN A. BELTRAN</b>		22e. ADDRESS <b>1940 W. BALTIMORE ST., BALTIMORE, MD.</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>12/20/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Md. Nat'l Cem.</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Md.</b>		23e. DATE REC'D. BY REGISTRAR <b>DEC 20 1982</b>			
24. FUNERAL DIRECTOR NAME <b>Chas. H. Pirell</b>		ADDRESS <b>414 319 N. Schroeder</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Conish</b>	

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified as required by law.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Passed may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove co-burial papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

BP.

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DEC 20 1982

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 42 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 is marked, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

FOR  
1- STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 3 1 9 4 8

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>FRANKLIN Thomas TERRY</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>12 5 82</b>			2b. HOUR <b>1:58 PM</b>				
3. SEX <b>MALE</b>		4. RACE <b>CAUCASIAN</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>9 30 39</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>43</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTO. CITY</b> MD.				
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SOUTH BALTO. GEN. HOSP</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>State Govt. Clerk</b>		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) <b>MARYLAND</b>			13b. COUNTY <b>---</b>		13c. CITY OR TOWN <b>BALTO CITY</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>1087 WILLIAMS ST.</b> 21230	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Fred Terry -</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Lucille M. Cogswell</b>			16. ADDRESS <b>Glen Burnie, Md. 21067</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>Yes</b> <b>Korea</b>			16b. SOCIAL SECURITY NO. <b>216-26-8332</b>		17. INFORMANT <b>Nancy M. Johnson</b> <b>404 First Ave., S.W.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: <b>4100 IMMEDIATE CAUSE (a) PROBABLE MYOCARDIAL INFARCTION</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 hrs 45 mins</b>		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (b) <b>HYPERTENSION</b> DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) <b>N/A</b>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) this hospital attended the deceased from <b>12/5</b> 19 <b>82</b> , to <b>10/5</b> 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>12/5</b> 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Roy W. Cragway Jr. M.D.</b>			DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>12/5/82</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ROY W. CRAGWAY JR. M.D.</b>			22e. ADDRESS <b>3001 S. HANOVER ST</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>			23b. DATE <b>12/7/1982</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Security Process, Inc.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Catonsville, Balto., Md.</b>			
24. FUNERAL DIRECTOR NAME <b>McCully Funeral Homes</b>			BALTO., MD., 21225 <b>237 E. Patapsco Ave.,</b>		25a. DATE REC'D. BY REGISTRAR <b>DEC 7 - 1982</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Conner</b>			

MEDICAL CERTIFICATION

2403 BP



FRANKLIN TERRY

WALTON 2 20 01

U 2 A

SOUTH BAYVIEW RD. HOPE

BRAND — BAYVIEW CITY

1000 WILLIAM ST

PROBABLY MISCELLANEOUS INFORMATION

UNRECORDED

W/A

JOHN W. CAMPBELL JR. M.D.  
JOHN W. CAMPBELL JR. M.D.

2001 2 HANOVER ST

DEC 7 - 1982

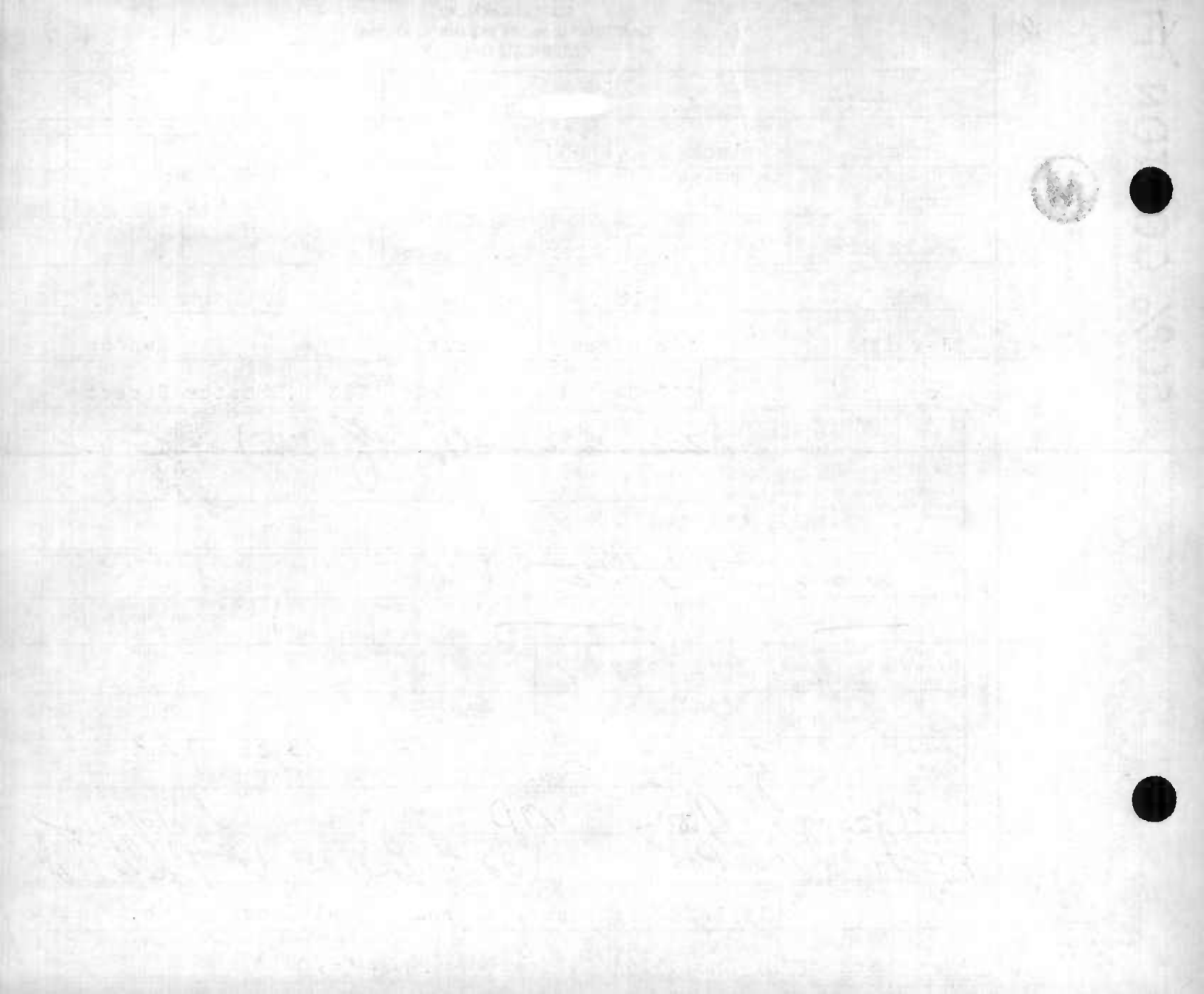
John Campbell

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 2 3 1 9 4 9			
1. FOR STATE REGISTRAR				CERTIFICATE OF DEATH			
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH			
FIRST MIDDLE LAST				MONTH DAY YEAR			
Evelyn L. Thomas				12 8 82			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	
Female		Black		MONTH DAY YEAR 11 8 09		73 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Maryland		USA				Baltimore City, MD	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
Baltimore		1213 N. Chester St.				12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
Md.		Balto.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		13f. STREET ADDRESS			
Jermiah Nicholson		Hattie Henson		1213 N. Chester St. 21213			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS			
No		212-36-2415		Toya Ball 1213 N. Chester Street			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>adenocarcinoma (probable ovarian)</u> 1830 DUE TO, OR AS A CONSEQUENCE OF (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5 mos</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>malignant ascites</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>6/9</u> , 19 <u>82</u> , to <u>12/5</u> , 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>12/3</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>E. Joseph Mon</u>		DEGREE <u>MD</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>12/9/82</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>ET JOSEPH MON</u>		22e. ADDRESS <u>22 S. Greene St Baltimore Md</u>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial		12/14/82		Cedar Hill Cem		Baltimore Co. Md.	
24. FUNERAL DIRECTOR NAME ADDRESS				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Wm C March F/H, Inc 1101 E. North Ave				12-9-82			





DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		20. DATE KNOWN OF DEATH		ESTIMATED		MONTH		DAY		YEAR		26. HOUR					
Grafton		H.		Thomas				20. DATE KNOWN OF DEATH		ESTIMATED		xx 12		5		19 82		M					
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR		2d. HOUR			
male		Black		7 3 45		37 YRS.		MONTHS		DAYS		HOURS		MIN.		12 5		19 82		1:05			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH											
Maryland				USA				WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				Baltimore City MD											
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY											
Baltimore				1316 N. Calhoun Street/Rear																			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13a. STATE				13b. COUNTY				13c. CITY OR TOWN				13d. INSIDE CITY LIMITS?				13e. STREET ADDRESS			
Maryland								Baltimore				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				1529 Mountmor Ct. 21217							
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO.				17. INFORMANT				ADDRESS			
John J. Thomas				Mary L. Carey				No				212-46-5276				Mary L. Thomas 1529 Mountmor Ct.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART I DEATH WAS CAUSED BY: <u>Alcoholism</u>																							
IMMEDIATE CAUSE (a) <u>3030</u>																							
DUE TO, OR AS A CONSEQUENCE OF																							
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.																							
(b) _____																							
DUE TO, OR AS A CONSEQUENCE OF																							
(c) _____																							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																							
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?												20. AUTOPSY?							
																YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)															
				P.M. 19																			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION															
								STREET CITY OR TOWN COUNTY STATE															
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																							
ACTUAL SIGNATURE				M.D.				TITLE (SPECIFY)				DATE SIGNED											
Margarita A. Korell				M.D.				Assistant				12/5/82											
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS																			
Margarita A. Korell, M.D.				111 Penn Street, Balto., MD 21201																			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION				COUNTY				STATE			
BURIAL				12/10/82				Arbutus Mem. Pk.				Arbutus				Md.							
24. FUNERAL DIRECTOR NAME				ADDRESS				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE											
Wm. C. March F/H Inc.				1101 E. North Ave.				DEC 6 - 1982				John J. Corbett											

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF NECESSARY, IT IS NECESSARY, PLEASE  
 EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18, GIVE PAGES 1 AND 2 TO THE FUNERAL DIRECTOR.  
 PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW. GIVE PAGE 5 FOR YOUR FILES.  
**TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS  
 AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET,  
 BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR MOVAL

DHMH - 17  
(VR A15 ME (5))  
20M 4/82





RECEIVED

100

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY. IF NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN ORIGINAL FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

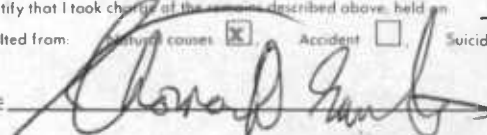

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 31951	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) <b>James Thomas</b>										2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH <b>12</b> DAY <b>21</b> YEAR <b>1982</b>	
3. SEX <b>male</b> 4. RACE <b>Colr</b> 5. DATE OF BIRTH <b>9-15-1906</b> 6. AGE (IN YEARS) <b>76</b> YRS. 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Dorham, Ala</b> 8. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b> 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b>										2b. HOUR <b>AM</b>	
10. CITY OR TOWN OF DEATH <b>Baltimore</b> 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>1201 Myrtle Avenue</b> 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Orderly</b> 12b. KIND OF BUSINESS OR INDUSTRY										2c. DATE PRONOUNCED DEAD <b>12 21 1982</b> 2d. HOUR <b>12:30</b>	
13a. STATE <b>Maryland</b> 13b. COUNTY <b>BALTO.</b> 13c. CITY OR TOWN <b>BALTO.</b> 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS <b>1201 Myrtle Ave.</b>											
14. FATHER'S NAME (FIRST MIDDLE LAST) <b>Unknown</b> 15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST) <b>Unknown</b>											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b> 16b. SOCIAL SECURITY NO. <b>260-07-9953</b> 17. INFORMANT (NAME AND ADDRESS) <b>Mr. Lewis Redd 2946 St. Lukes Lane</b>											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> <b>4292</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <b>Chronic alcoholism</b>											
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	
20a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH										20b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>	
21a. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>										21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)										21d. LOCATION (CITY OR TOWN COUNTY STATE)	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <b>Hormez R. Guard</b> M.D. TITLE (SPECIFY) <b>Assistant</b> MEDICAL EXAMINER DATE SIGNED <b>12/21/82</b>											
EXAMINER'S NAME (TYPE OR PRINT) <b>Hormez R. Guard, M.D.</b> ADDRESS <b>111 Penn Street, Baltimore, MD 21201</b>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b> 23b. DATE <b>12-27-82</b> 23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Zion Cem.</b> 23d. LOCATION (CITY OR TOWN COUNTY STATE) <b>Handouwe Md.</b>											
24. FUNERAL DIRECTOR NAME <b>Joseph L. Russ</b> ADDRESS <b>2222 W. North Ave</b> 25a. DATE REC'D. BY REGISTRAR <b>DEC 27 1982</b> 25b. REGISTRAR'S SIGNATURE <b>Joan J. Carver</b>											

MEDICAL CERTIFICATION

UNITED STATES DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY

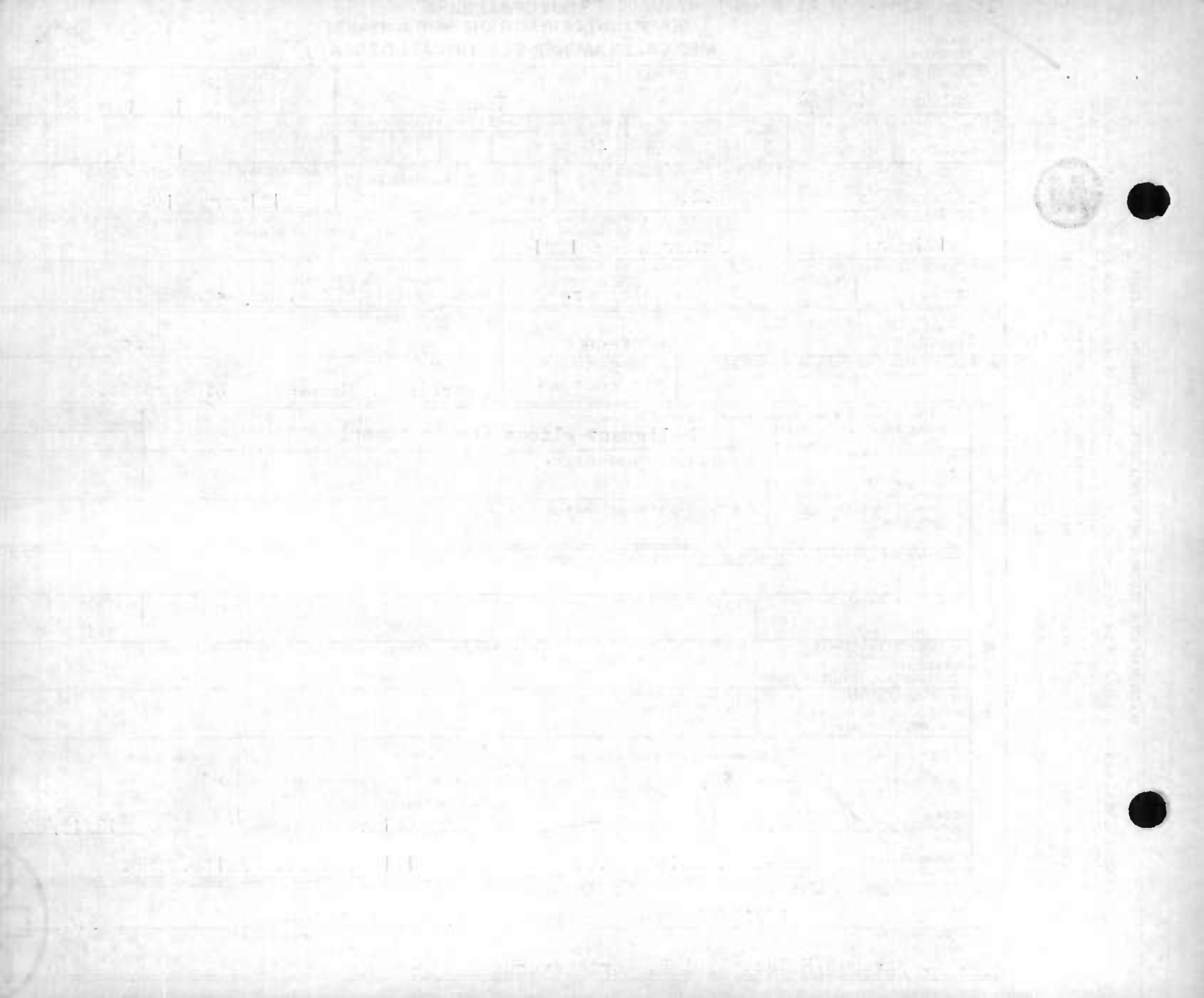
Very respectfully,  
Yours truly,  
[Signature]  
[Name]  
[Title]  
[Address]  
[City]  
[State]  
[Country]



1. DECEASED NAME (TYPE OR PRINT) <b>Julia (Judy) Thomas</b>			2a. DATE KNOWN OF DEATH MONTH <b>12</b> DAY <b>14</b> YEAR <b>1982</b>			2b. HOUR <b>M</b>		
3. SEX <b>Female</b>	4. RACE <b>Black</b>	5. DATE OF BIRTH MONTH <b>3</b> DAY <b>9</b> YEAR <b>42</b>	6. AGE (IN YEARS) LAST BIRTHDAY <b>40</b> YRS.	IF UNDER 1 YR. MONTHS <b>0</b> DAYS <b>0</b>	IF UNDER 24 HRS. HOURS <b>0</b> MIN. <b>0</b>	2c. DATE PRONOUNCED DEAD MONTH <b>12</b> DAY <b>14</b> YEAR <b>1982</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>S. Carolina</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City, MD.</b>		
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Lutheran Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE <b>Maryland</b>								
13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>817 N. Augusta Ave. 21229</b>		
14. FATHER'S NAME FIRST <b>Issac</b> MIDDLE <b>Anderson</b> LAST <b>Anderson</b>			15. MOTHER'S MAIDEN NAME FIRST <b>Ada</b> MIDDLE <b>Eaddy</b> LAST <b>Eaddy</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>215-40-5089</b>		17. INFORMANT ADDRESS <b>Curtis A. Thomas 706 Linnard St.</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Malignant glioma (brain tumor)</b> <b>1919</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that I took charge of the deceased described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: <input checked="" type="checkbox"/> Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE 		TITLE (SPECIFY) <b>Deputy Chief</b>				DATE SIGNED <b>12/15/82</b>		
EXAMINER'S NAME (TYPE OR PRINT) <b>Thomas D. Smith, M.D.</b>		ADDRESS <b>111 Penn ST. Balto., MD.</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>12/21/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Grove Bapt. Ch. Andrews S.C.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE		
24. FUNERAL DIRECTOR NAME <b>Wm. C. March F/H Inc, 1101 E. North Avenue</b>				25a. DATE REC'D. BY REGISTRAR <b>DEC 16 1982</b>		25b. REGISTRAR'S SIGNATURE 		

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED IN YOUR FILES. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- STATE REGISTRAR		2a. DATE KNOWN OF DEATH		MONTH DAY YEAR		2b. HOUR	
1 DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST	
Tony		A.		Thomas			
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	IF UNDER 1 YR.	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD	2d. HOUR
male	Black	MONTH DAY YEAR	LAST BIRTHDAY	MONTHS	DAYS	12 21 82	7:26 a.m.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		
Maryland	U.S.A.				Baltimore City, MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Baltimore	Johns Hopkins Hospital						
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS			
Maryland		Baltimore	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	1724 Ashland Ave. 21205			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME					
FIRST MIDDLE LAST		FIRST MIDDLE LAST					
Richard A. Thomas		Arnetta Artson					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
No		N/ A		Arnetta Artson 1724 Ashland Avenue			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I DEATH WAS CAUSED BY:							
IMMEDIATE CAUSE (a) Sudden Infant Death Syndrome							
7980							
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.							
(b) DUE TO, OR AS A CONSEQUENCE OF							
(c) DUE TO, OR AS A CONSEQUENCE OF							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?	
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
		HOUR A.M. MONTH DAY YEAR					
		P.M. 19					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION			
				CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE		TITLE (SPECIFY)				DATE SIGNED	
Hormez R. Guard, M.D.		M.D. Assistant MEDICAL EXAMINER				12-23-82	
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS					
Hormez R. Guard, M.D.		111 Penn Street					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION	
BURIAL		12/27/82		Arbutus Memorial Park		Arbutus Md.	
24. FUNERAL DIRECTOR NAME				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Wm. C. March F/H Inc. 1101 E. North Avenue				DEC 29 1982			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED IN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

RECEIVED  
FEBRUARY 1964



RECEIVED  
FEBRUARY 1964



RECEIVED  
FEBRUARY 1964



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 48 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

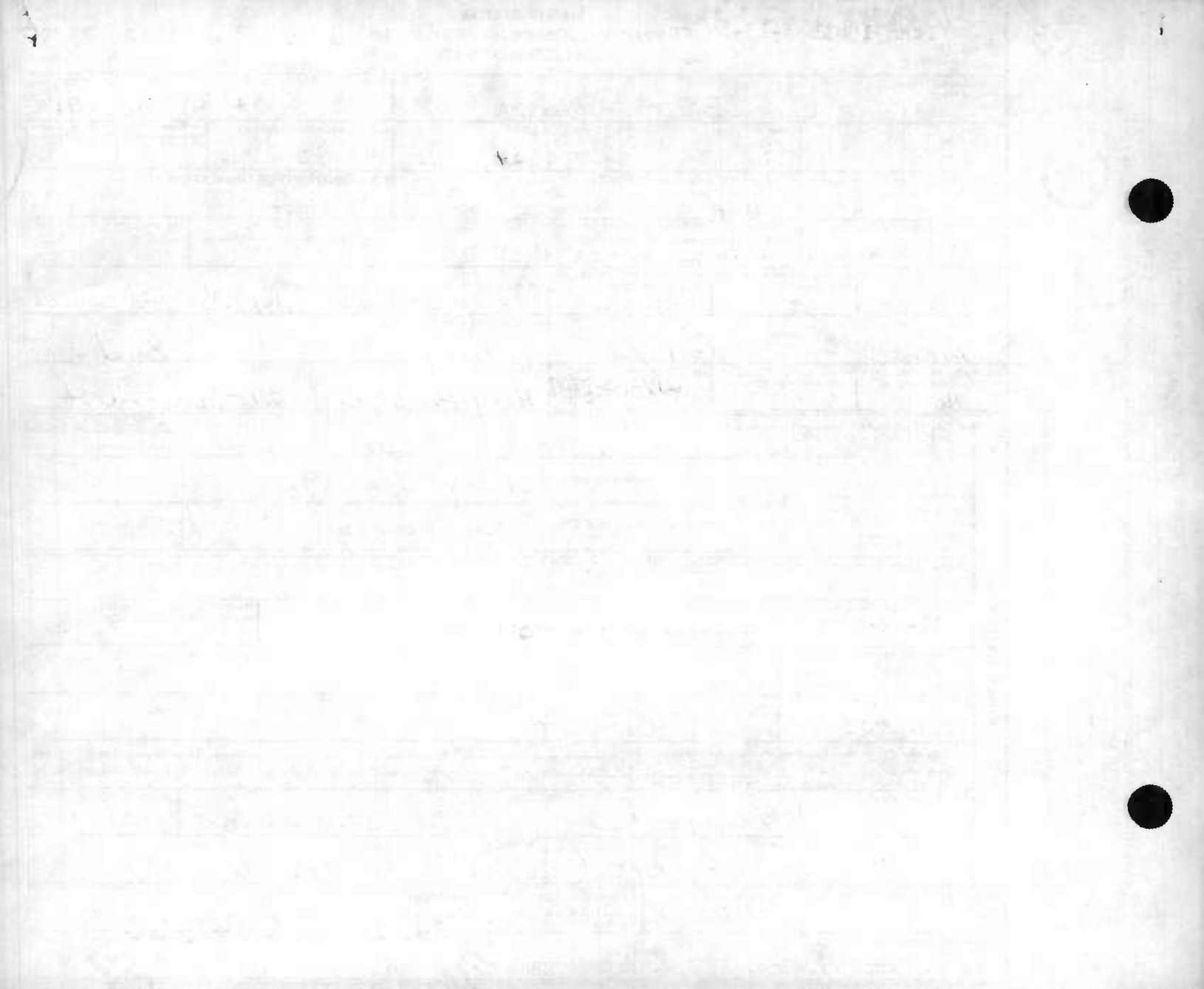
IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

Item 16b 575 1/12/83 GAB  
FOR Item 19a & b 3-13-84 cnSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 3 1 9 5 4

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) Viola B. Thomas			2a. DATE OF DEATH MONTH DAY YEAR 12/27/1982			2b. HOUR 9A M					
3 SEX F		4 RACE B		5 DATE OF BIRTH MONTH DAY YEAR 5/24/1912		6 AGE (IN YEARS LAST BIRTHDAY) 70 YRS.		7 UNDER 1 YEAR MONTHS DAYS		8 UNDER 24 HRS HOURS MIN.	
9a BIRTHPLACE (STATE OR FOREIGN COUNTRY) S. Carolina		9b CITIZEN OF WHAT COUNTRY? USA		10 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		11 BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.					
12 CITY OR TOWN OF DEATH CITY Baltimore		13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Lutheran Hospital of M.D.				14a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		14b. KIND OF BUSINESS OR INDUSTRY			
15a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 15a STATE H.D. 24111						15b CITY OR TOWN Baltimore		15c INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		15d STREET ADDRESS 2210 Ashburton St. 21216	
16 FATHER'S NAME FIRST MIDDLE LAST Pierce Gilliam			17 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Boyd			18a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			18b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 215 845 608		
19 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 0389 IMMEDIATE CAUSE (a) Sepsis, Septic shock DUE TO, OR AS A CONSEQUENCE OF (b) ABOthermic s/p BK DUE TO, OR AS A CONSEQUENCE OF (c) anginal Pk						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a DATE OF OPERATION 11-22-82			19b CONDITION FOR WHICH OPERATION WAS PERFORMED Gangrene of the right leg			20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE S. Suwanagool			DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c DATE SIGNED 12/27					
22d PHYSICIAN'S NAME (TYPE OR PRINT) S. Suwanagool			22e ADDRESS Lutheran Hospital MD								
23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b DATE 1/4/83		23c NAME OF CEMETERY OR CREMATORY Arbutus Mem. Pk.			23d LOCATION CITY OR TOWN COUNTY STATE Arbutus Md.			
24 FUNERAL DIRECTOR NAME Wm. C. March F/H Inc. 1101 E. North Avenue						25a DATE REC'D. BY REGISTRAR JAN 4 1983		25b REGISTRAR'S SIGNATURE John J. Lohr			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene. If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

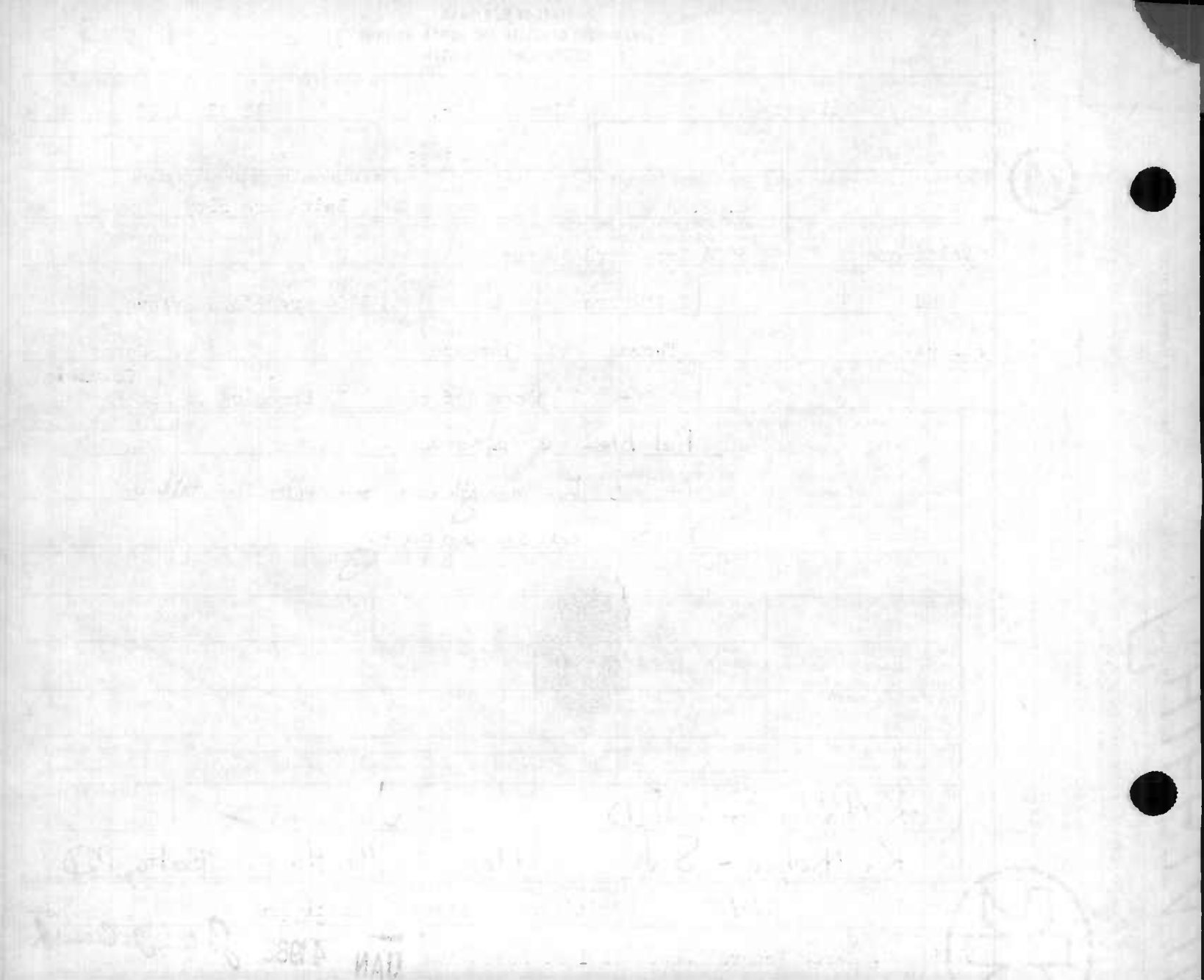
FOR  
1 - STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 3 1 9 5 5

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR			
FIRST MIDDLE LAST Wilbert Thomas Sr.			MONTH DAY YEAR 12 29 1982			M			
3. SEX male		4. RACE black		5. DATE OF BIRTH MONTH DAY YEAR 2 20 1923		6. AGE (IN YEARS LAST BIRTHDAY) 59 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Va		7b. CITIZEN OF WHAT COUNTRY? U. S. A		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore city MD.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 5904 Frankford Avenue				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 5904 Frankford Avenue	
14. FATHER'S NAME FIRST MIDDLE LAST Althea Thomas				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Florence Jones					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No				16b. SOCIAL SECURITY NO. 225-20-4683		17. INFORMANT ADDRESS Joan Jeffries 8875 Famebird Ct Apt K Columbia Md			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Probable arrhythmia 4254 DUE TO, OR AS A CONSEQUENCE OF (b) Pt. 2 by arrhythmia & biventricular failure DUE TO, OR AS A CONSEQUENCE OF (c) EtOH cardiomyopathy								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE K. Robie Suh MD						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) K. Robie - Suh						22e. ADDRESS Univ. of Md. Hosp. Balto, MD			
23a. BURIAL, CREMATION, REMOVAL Burial			23b. DATE 1/4/83		23c. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore - Md		
24. FUNERAL DIRECTOR NAME William C. March Funeral Home						25a. DATE REC'D. BY REGISTRAR JAN 4 1983		25b. REGISTRAR'S SIGNATURE John J. Smith	
ADDRESS 1101 E. North Ave									



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 2 3 1 9 5 6			
1- FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>Annetta Margaret Thompson</b>				2a. DATE OF DEATH MONTH <b>12</b> DAY <b>23</b> YEAR <b>82</b>			
3. SEX <b>Female</b>				2b. HOUR <b>3<sup>10</sup> A M</b>			
4. RACE <b>White</b>		5. DATE OF BIRTH MONTH <b>2</b> DAY <b>5</b> YEAR <b>1915</b>		6. AGE (IN YEARS (LAST BIRTHDAY)) <b>67</b> YRS.		IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Good Samaritan Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>House Wife</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Maryland</b>		13b. CITY OR TOWN <b>Baltimore</b>		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>7719 Fairgreen Road</b>	
14. FATHER'S NAME FIRST <b>Francis</b> MIDDLE <b>A.</b> LAST <b>Martin</b>		15. MOTHER'S MAIDEN NAME FIRST <b>Margaret</b> MIDDLE <b>A.</b> LAST <b>Reiser</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			
16b. SOCIAL SECURITY NO. <b>220-30-1787</b>		17. INFORMANT <b>Carroll E. Thompson</b>		ADDRESS <b>7719 Fairgreen Rd. Balto. MD 21222</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: <b>1749</b> IMMEDIATE CAUSE (a) <b>metastatic Breast Ca</b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
DUE TO, OR AS A CONSEQUENCE OF							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Mittal</b>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>14 23/82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>MITTAL</b>				22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>12/24/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Maryland</b>	
24. FUNERAL DIRECTOR NAME <b>Duda-Ruck, Inc.</b> ADDRESS <b>7922 Wise Avenue, Dundalk, MD 21222</b>				25. DATE REC'D. BY REGISTRAR <b>DEC 27 1982</b> 26. REGISTRAR'S SIGNATURE <b>John J. Carver</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified and a separate report filed.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8 2 3 1 9 5 7				
1- FOR STATE REGISTRAR					REG. NO.									
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH					2b. HOUR				
Eugene Thompson					12 29 82					M				
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)				IF UNDER 1 YEAR		IF UNDER 24 HRS.		
F		B		7 9 19		63 YRS				MONTHS DAYS		HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH								
N. Carolina		U.S.A.				Baltimore City, MD.								
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
Baltimore		21 S. Rosedale Street												
13a. STATE					13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
Maryland							Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		21 S. Rosedale St. 21229			
4. FATHER'S NAME					15. MOTHER'S MAIDEN NAME									
Eugene L. Carmichael					Julett McCall									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS							
No					N/a		John E. Thompson 21 S Rosedale St.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
1990 IMMEDIATE CAUSE (a) Carcinomatosis														
DUE TO, OR AS A CONSEQUENCE OF (b)														
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last														
DUE TO, OR AS A CONSEQUENCE OF (c)														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)														
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
				8 (P.M.) 12 29 1982										
21d. INJURY OCCURRED				21e. PLACE OF INJURY		21f. LOCATION								
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from July, 19 82, to Dec, 19 82, that (I) (we) lost saw the deceased alive on 12/19/19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE				DEGREE				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL STAFF <input type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED		
ADIL TOTOUNCHIE								Bon Secours Hosp.				12/31/82		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS										
23a. BURIAL, CREMATION, REMOVAL				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION						
BURIAL				1/6/83		Center Grove Cem		Red Springs N.C.						
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE						
Wm. C. March F/H Inc. 1101 E. North avenue				JAN 4 1983				J. J. J. J.						





4100 JAN 1964

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 1B shows any injury, or other traumatic event, the medical examiner must be called at once.DHMH-16 30M 2/80  
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR <i>Eva C. Thompson</i> REG. NO. <i>8231958</i>									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>EVA C. THOMPSON</i>						2a. DATE OF DEATH MONTH DAY YEAR <i>12-11-82</i>		2b. HOUR <i>2:15 P.M.</i>	
3. SEX <i>FEMALE</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>09-08-1891</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>91</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7. BIRTHPLACE (STATE AND FOREIGN COUNTRY) <i>Balto. City, MARYLAND</i>		8. CITIZEN OF WHAT COUNTRY? <i>USA</i>		9. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Balto. City City, MD.</i>			
10. CITY OR TOWN OF DEATH <i>BALTIMORE</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>BON SECOURS HOSP.</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>-----</i>	
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE <i>MARYLAND</i>		13b. COUNTY <i>USA</i>		13c. CITY OR TOWN <i>BALTIMORE</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <i>110 N. Potomac St. 433-1111-1111</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>HENRY W. MAENNER</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>CERTUDE B. ROCK</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NO</i>				16b. SOCIAL SECURITY NO. <i>212 58 1028</i>		17. INFORMANT <i>110 N. Potomac St. - Balto.,</i> <i>Miss Dorothy M. Thompson Md. 21224.</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <i>7070</i> IMMEDIATE CAUSE (a) <i>CARDIO PULMONARY FAILURE</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>INFECTED MULTIPLE DECUBITUS ULCERS</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>THUNK, LOWER EXTREMITY</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <i>MULTIPLE INFECTED DECUBITUS ULCERS BACK THUNK, LT. LEG.</i>									
19a. DATE OF OPERATION <i>12-24-82</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>DECUBITUS ULCER LT. ISCHAL</i>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. - 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2) <i>-----</i>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <i>09/15</i> , 19 <i>82</i> , to <i>12-11</i> , 19 <i>82</i> , that (I) (we) lost saw the deceased alive on <i>12-24</i> , 19 <i>82</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>John A. Mor...</i> DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						22c. DATE SIGNED <i>12-11-82</i>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>BAMROING LERDISOON</i>				22e. ADDRESS <i>4713 LEADS AVE BALTIMORE MD 21227</i>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>Dec. 15, 1982</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Sacred Heart Cem.</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Baltimore, Md.</i>			
24. FUNERAL DIRECTOR NAME <i>John A. Mor...</i>				25a. DATE REC'D. BY REGISTRAR <i>DEC 13 1982</i>		25b. REGISTRAR'S SIGNATURE <i>John J. Connel</i>			

3000 E. Baltimore St. - Baltimore, Md. 21223



110 W. ...

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110 W. ...

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 3 1 9 5 9	
FOR 1. STATE REGISTRAR					REG. NO.						
1. DECEASED NAME (TYPE OR PRINT) Leon N. Thompson, Sr.					2a. DATE OF DEATH MONTH DAY YEAR 12 19 82				2b. HOUR M		
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 12 7 38		6. AGE (IN YEARS LAST BIRTHDAY) 44 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 74 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 962 Stoddard Court				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Maryland		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 962 Stoddard Court 21201			
14. FATHER'S NAME FIRST MIDDLE LAST Herb Thompson					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Edna Chase						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 217-34-9647		17. INFORMANT ADDRESS Leon N. Thompson Jr. 218 Midpine Court Apt. 4C							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>gunshot wound</u> 1629 DUE TO, OR AS A CONSEQUENCE OF (b) <u>metastatic lung Ca</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: 10											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) (this hospital) attended the deceased from 12/11, 19 82, to 12/19, 19 82, that (1) (we) lost saw the deceased alive on 12/18, 19 82, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.											
22b. SIGNATURE B. H. H. M.						DEGREE MD			22c. DATE SIGNED 12/23/82		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Brian H. H. M.						22e. ADDRESS 22 S Green St. Balt, Md 21201					
23a. BURIAL, CREMATION, REMOVAL BURIAL			23b. DATE 12/23/82		23c. NAME OF CEMETERY OR CREMATORY Arbutus Mem. Pk.			23d. LOCATION CITY OR TOWN COUNTY STATE Arbutus Md.			
24. FUNERAL DIRECTOR NAME ADDRESS Wm. C. March F/H Inc. 1101 E. North Avenue						25a. DATE RECEIVED BY REGISTRAR DEC 23 1982			25b. REGISTRAR'S SIGNATURE John J. Connel		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Page 4 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 2 3 1 9 6 0			
1. FOR STATE REGISTRAR				CERTIFICATE OF DEATH			
I. DECEASED NAME (TYPE OR PRINT)				REG. NO.			
1a. DECEASED NAME (TYPE OR PRINT) <b>MARIE - SLADE Thompson</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>12-3-82</b> 2b. HOUR <b>9<sup>22</sup> P.M.</b>			
3. SEX <b>Female</b>		4. RACE <b>NEGRO</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>3-8-22</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>60</b> YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Va.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City MD.</b>	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Deaton Medical Center</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Nurses Aid</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Nursing Home</b>	
13a. STATE <b>Md.</b>		13b. COUNTY		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>John</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Pinkey Hatcher</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			
16b. SOCIAL SECURITY NO. <b>215-22-6145</b>		17. INFORMANT ADDRESS <b>Audrey Kay 7K Solar Circle</b>					
18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c))							
PART I. DEATH WAS CAUSED BY:							
IMMEDIATE CAUSE (a) <b>Renal failure &amp; Nephrosis</b>							
DUE TO, OR AS A CONSEQUENCE OF (b) <b>Hypertensive CVD.</b>							
DUE TO, OR AS A CONSEQUENCE OF (c) <b>Diabetes mellitus</b>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>CVA &amp; Hemiplegia</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I (this hospital) attended the deceased from <b>12/3/82</b> to <b>12/3/82</b> , that I (we) last saw the deceased alive on <b>12/3/82</b> , and that in (our) opinion death occurred on the date and hour and from the causes stated above, I (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>J. R. Gladue, MD</b>				DEGREE <b>MD</b>		22c. DATE SIGNED <b>12/6/82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Removal</b>		23b. DATE <b>12-9-82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Hatcher Family Ctry. Cumberland</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Va.</b>	
24. FUNERAL DIRECTOR NAME <b>Randolph J. Collick</b> ADDRESS <b>2431 E. Oliver St.</b>				25a. DATE REC'D. BY REGISTRAR <b>Dec. 6, 1982</b> 25b. REGISTRAR'S SIGNATURE			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certain papers. Pages 1 and 2 should be filed with the health department after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. FOR STATE REGISTRAR				2b. DATE OF DEATH MONTH DAY YEAR 12 20 82			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST TYLETA THOMPSON				2b. HOUR 7-45 PM			
3. SEX FEMALE		4. RACE B		5. DATE OF BIRTH MONTH DAY YEAR 07 09 25		6. AGE (IN YEARS LAST BIRTHDAY) 57	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) JAMICA		7b. CITIZEN OF WHAT COUNTRY? US of A		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SINAI HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) NURSE		12b. KIND OF BUSINESS OR INDUSTRY PRIVATE DUTY	
13a. STATE MD				13b. COUNTY		13c. CITY OR TOWN BALTIMORE	
14. FATHER'S NAME FIRST MIDDLE LAST UNKNOWN				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UNKNOWN			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 218 64 6520		17. INFORMANT ADDRESS APT. A 1 ABDELL VASSELL 4001 W. NORTHERN PKWY			
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 2028 MENINGEAL LYMPHOMATOSIS DUE TO, OR AS A CONSEQUENCE OF (b) MALIGNANT LYMPHOMA DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 11/17/82 to 12/20/82, that (I) (we) last saw the deceased alive on 12/20/82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Uma Prasad MBBS				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 12/29/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) UMA PRASAD				22e. ADDRESS SINAI HOSPITAL			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 12/24/82		23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE (AA Co.) MD.	
24. FUNERAL DIRECTOR NAME ADDRESS LEWIS T. GWYNN 4517 PARK HEIGHTS AVENUE				25a. DATE REC'D. BY REGISTRAR DEC 27 1982		25b. REGISTRAR'S SIGNATURE John J. Connel	

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JAMES T. GUYAN

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 3 1 9 6 2 REG. NO.			
1. FOR STATE REGISTRAR							
1. DECEASED NAME FIRST MIDDLE LAST <b>CAROLINE YANCEY TIGHE</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>DECEMBER 19, 1982</b>			
2b. TIME OF DEATH <b>12-30 P.M.</b>							
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Oct. 16 1900</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>82</b> YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>North Carolina</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>221 Ridgemoor Rd.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Maryland</b>		13b. COUNTY		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>John Yancey</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Caroline Motz</b>		16. STREET ADDRESS <b>221 Ridgemoor Rd. 21210</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <input type="checkbox"/> <b>No</b>		16b. SOCIAL SECURITY NO. <b>220-44-3702</b>		17. INFORMANT <b>Richard R. Tighe Kansas City, Mo.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>4409 Rupture of Abdominal Aortic Aneurysm</b> IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerosis.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <b>Sudden.</b> <b>? Years</b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>2/17/1949</b> , 19____, to <b>12/19/82</b> , 19____, that (I) (we) lost saw the deceased alive on <b>8/20/82</b> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.							
22b. SIGNATURE <b>Edwin B. Jarrett</b>				DEGREE <b>M.D.</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Edwin B. Jarrett, M.D.</b>				22e. ADDRESS <b>11 E. Chase St. Baltimore, Md. 21202</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>Dec. 23, 1982</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Greenmount</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore City, Maryland</b>	
24. FUNERAL DIRECTOR NAME <b>Mitchell-Wiedefeld Home, Inc. Balto., Md. 21212</b>				25a. DATE REG'D. BY REGISTRAR <b>DEC 22 1982</b>			
25b. SIGNATURE <b>[Signature]</b>							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
1. FOR STATE REGISTRAR					8 2 3 1 9 6 3 REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) WILLIAM B. TILGHMAN III					2a. DATE OF DEATH MONTH DAY YEAR 12 26 82			2b. HOUR 12:40 P.M.	
3. SEX MALE		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 1 31 1923		6. AGE (IN YEARS LAST BIRTHDAY) 59 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.			
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) VETERANS ADMINISTRATION MEDICAL CENTER				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CONSULTANT		12b. KIND OF BUSINESS OR INDUSTRY INDUS. Eng.	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) D.C.		13b. COUNTY None		13c. CITY OR TOWN Washington		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS University Club 16th St N.W.	
14. FATHER'S NAME FIRST MIDDLE LAST Wm. B. TILGHMAN, JR.		15. MOTHER'S MAIDEN NAME MIDDLE LAST MA Belle STERLING							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWII NAVY		17. INFORMANT 114 W. University PK # 23 BALTIMORE, MD. 21210					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4549 IMMEDIATE CAUSE (a) RESPIRATORY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) VARICEAL BLEED Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) HEPATOMA APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1/2 hr. 1/2 hr. 2-3 mos.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a: ALCOHOLIC CIRRHOSIS OF LIVER									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from DECEMBER 12, 1982, to DECEMBER 26, 1982, that (I) (we) last saw the deceased alive on DECEMBER 26, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Carla S. Alexander, MD		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 12/27/82					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) CARLA S. ALEXANDER, MD		22e. ADDRESS 3900 Loch Raven Blvd. Balto., Md. 21218							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 12/29/1982		23c. NAME OF CEMETERY OR CREMATORY PARSONS Cem.		23d. LOCATION CITY OF TOWN COUNTY STATE Salisbury Wic Md.			
24. FUNERAL DIRECTOR NAME Baker & Bounds		ADDRESS Salisbury, Md.		25a. DATE REC'D. BY REGISTRAR DEC 30 1982		25b. REGISTRAR'S SIGNATURE John J. Smith			

BP





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 3 1 9 6 4

REG. NO.

1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		FIRST LEWIS	MIDDLE R.	LAST TIPPETT	2a. DATE OF DEATH MONTH DAY YEAR	12-17-82	2b. HOUR 7:00pm
3. SEX MALE	4. RACE CAUCASIAN	5. DATE OF BIRTH MONTH DAY YEAR	09 24 10	6. AGE (IN YEARS LAST BIRTHDAY)	72	YRS	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) MACHINIST	12b. KIND OF BUSINESS OR INDUSTRY STEEL	MD.			
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CHURCH HOME HOSPITAL	12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND	13b. CITY BALTIMORE	13c. CITY OR TOWN ROSEDALE	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS 7938 BRIDGE AVE. 21237			
14. FATHER'S NAME FIRST MIDDLE LAST WILLIAM TIPPETT	15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ADA HAMMETT	16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO	16b. SOCIAL SECURITY NO. 213078619	17. INFORMANT ADDRESS ANNA TIPPETT 7938 BRIDGE AVE. 21237					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1: DEATH WAS CAUSED BY: 1850 IMMEDIATE CAUSE (a) CARCINOMA PROSTATE WITH METASTASIS DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 12-14-82 to 12-17-82, that (we) (we) last saw the deceased alive on 12-17-82, 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.									
22b. SIGNATURE A. F. Nazemi M.D.		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 12/17/82			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. A. F. NAZEMI M.D.		22e. ADDRESS CHURCH HOSPITAL CORPORATION 100 N. BROADWAY BALTIMORE, MARYLAND 21231							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 12/21/82		23c. NAME OF CEMETERY OR CREMATORY HOLY ROSARY		23d. LOCATION BALTO. BALTO. MD.			
24. FUNERAL DIRECTOR NAME J. G. Cook		ADDRESS 1211 Chesaco Ave 2037		25a. DATE REC'D DEC 20 1982		25b. REGISTRAR'S SIGNATURE John J. Carver			



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DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OF PRINT) FIRST MIDDLE LAST <b>Arlee (TLEE) Toliver</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>12-29-82</b>		2b. HOUR <b>8:10<sup>AM</sup></b>		
3. SEX <b>Female</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>12 7 02</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. <b>80</b>	
7a. PLACE OF BIRTH (STATE OR FOREIGN COUNTRY) <b>S.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD	
10. CITY OR TOWN OF DEATH <b>BaHo.</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Mercy Hosp.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>MD</b>		13b. COUNTY <b>BaHo</b>		13c. CITY OR TOWN <b>BaHo</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS <b>933 Webb Ct. 21202</b>		14. FATHER'S NAME FIRST MIDDLE LAST <b>N/A</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>N/A</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>	
16a. SOCIAL SECURITY NO. <b>N/A</b>		17. INFORMANT <b>Isabel A. Smith</b>		ADDRESS <b>Tinton Falls, N.J. 40 Williams St.</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4280 Congestive Heart Failure</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <b>Digoxin toxicity</b>							
9a. DATE OF OPERATION		19a. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>12-22-82</b> to <b>12-29-82</b> , that (I) (we) last saw the deceased alive on <b>12-29-82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Constance J. Meyd</b>		DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>12-29-82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Constance J. Meyd MD</b>		22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>1/3/83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arbutus Memorial Pk.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Arbutus Md.</b>	
24. FUNERAL DIRECTOR NAME <b>Wm. C March F/H Inc.</b>		ADDRESS <b>1101 E. North Avenue</b>		25a. DATE REC'D. BY REGISTRAR <b>JAN 4 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Conner</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of such.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		12 10 82		7 30 AM	
Frederick TOPOLSKY Topolsky							
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR		IF UNDER 24 HRS	
Male	Caucasian	MONTH DAY YEAR	58	MONTHS DAYS		HOURS MIN.	
		XIX 13 24					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
NEW YORK	USA			BALTIMORE CITY MD.			
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Baltimore City	Schenck Hospital	MECHANIC		AUTO			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. INSIDE CITY LIMITS?		13b. STREET ADDRESS			
13a. STATE COUNTY		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		3707 Lamoine Rd		21133	
Md. Balto.							
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME					
FIRST MIDDLE LAST		FIRST MIDDLE LAST					
HYMAN TOPOLSKY		ALICE BERLIN					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT			
YES		WWII		MRS. BETTY H. TOPOLSKY			
		123-14-2251		3707 LAMOINE RD. RANDALLSTOWN, MD 21133			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY:							
IMMEDIATE CAUSE (a) Cardio pulmonary arrest							
1889							
DUE TO, OR AS A CONSEQUENCE OF							
(b) Metastatic bladder cancer							
DUE TO, OR AS A CONSEQUENCE OF							
(c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 16c							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)			
		HOUR A.M. MONTH DAY YEAR					
		P.M. 19					
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION			
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 12/9/82 to 12/10/82, that (I) (we) last saw the deceased alive on 12/9/82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE		DEGREE		22c. DATE SIGNED			
Leon Strauss		MD		12 10 82			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS					
Leon Strauss MD		Schenck Hospital Baltimore Md					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION	
BURIAL		DEC. 12, 1982		AITZ CHAIM		BALTIMORE MARYLAND	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
SOL LEVINSON & BROS., INC.		DEC 15 1982		John J. Conner			
NAME		ADDRESS					
6010 REISTERSTOWN RD. BALTO., MD 21215							

Page 1 of 1

10/10/10

1	2	3	4	5	6	7	8	9	10
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181	182	183	184	185	186	187	188	189	190
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it must be signed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 must be buried with the body within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
8 2 3 1 9 6 7									
1- STATE REGISTRAR									
REG. NO.									
1. DECEASED NAME (TYPE OR PRINT) FRANK EDWARD TRENTZSCH, Jr.						2a. DATE OF DEATH MONTH DAY YEAR 12 3 82		2b. HOUR 12:20 P <sub>M</sub>	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YR 12 26 19		6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore, Md.		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY, MD.			
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) VAMC LOCH RAVEN BALTIMORE MD.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Welder-U.S. Navy 12b. KIND OF BUSINESS OR INDUSTRY WELDER CIV.			
13a. STATE MARYLAND		13b. COUNTY ---		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 3419 E. FAIRMOUNT AVE. 21224	
14. FATHER'S NAME FIRST MIDDLE LAST Frank E. Trentzsch, Sr.				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mollie Frei					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWII		17. INFORMANT ADDRESS 3419 E. Fairmount Ave.-Balto., Mrs. Lorraine J. Trentzsch-Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> 4920 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Severe Emphysema</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 21224. 3:00pm 20 yrs.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: _____									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that <u>X</u> (this hospital) attended the deceased from <u>December 3</u> , 19 <u>82</u> , to <u>December 3</u> , 19 <u>82</u> , that <u>Xi</u> (we) lost saw the deceased alive on <u>December 3</u> , 19 <u>82</u> , and that in <u>X</u> (our) opinion death occurred on the date and hour and from the causes stated above. (We were asked to sign this certificate after the body of the deceased was removed.)									
22b. SIGNATURE <u>Charles E. Shreeve M.D.</u>				DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/3/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Charles E. Shreeve M.D.				22e. ADDRESS 3900 Loch Raven Blvd. Baltimore, Md 21218					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/7/82		23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland			
24. FUNERAL DIRECTOR NAME John D. Moran, Inc. 3000 E. Baltimore St. - Baltimore, Md. 21224				25a. DATE REC'D. BY REGISTRAR DEC 6 - 1982		25b. REGISTRAR'S SIGNATURE John J. Lohr			





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 2 3 1 9 6 8			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>THELMA M TRIPP</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>December 18 1982</b>		2b. HOUR <b>12 45</b> M	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Oct. 23, 1899</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>83</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY MD.</b>	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Keswick Nursing Home</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Clerk, Social</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Security Agency</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
13a. STATE <b>Maryland</b>		13b. COUNTY <b>---</b>		13c. CITY OR TOWN <b>Baltimore</b>		13e. STREET ADDRESS <b>3939 Roland Ave. Balto. Md. 21211</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Alonzo M. Tripp</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Georgia Belle Morgan</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NAME UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>			
16b. SOCIAL SECURITY NO. <b>215-01-2009</b>		17. INFORMANT ADDRESS <b>LeRoy E. Gending, Jr. 1107 North Point Blvd. Balto. Md. 21224</b>					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b> <b>4140</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic heart disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>years</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>days</b>							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>0</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>4-27</b> , 19 <b>82</b> , to <b>12-18</b> , 19 <b>82</b> , that (I) (we) lost saw the deceased alive on <b>12-18</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Shelly H. Thar</b>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>12-18-82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Dec. 21, 1982</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Meadowridge Mem. Park</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Howard Co Maryland</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>McCutty Funeral Home, 130 E. Fort Ave. Balto. Md. 21230</b>				25a. DATE REC'D. BY REGISTRAR <b>DEC 21 1982</b>			

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 3 1 9 6 9

1 - FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>JOSEPH TROMBETTA</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>DECEMBER 10 1982</b>		2b. HOUR <b>8:22AM</b>
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>July 24-1909</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>73</b>	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTO CITY</b> MD.	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Church Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE <b>MD.</b>			13c. CITY OR TOWN <b>BALTO.</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Bonaventura Trombetta</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Vito</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT ADDRESS <b>Theresa Winn-234 Albemarle ST</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIORESPIRATORY FAILURE</b> 2041 DUE TO, OR AS A CONSEQUENCE OF (b) <b>SEPTIC SHOCK</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) <b>CHRONIC LYMPHOCYTIC LEUKEMIA</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION OF DEATH <b>ADULT ONSET DIABETES MELLITUS; ATRIAL FIBRILLATION; ORGANIC BRAIN SYNDROME</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>12/4/</b> 19 <b>82</b> to <b>12/10</b> 19 <b>82</b> , that (I) <input checked="" type="checkbox"/> saw the deceased <input type="checkbox"/> did not view the body after death.					
22b. SIGNATURE <b>T. Kawaja</b>		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>12.10.82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>T. KAWAJA, M.D.</b>		22e. ADDRESS <b>CHURCH HOSPITAL CORPORATION 100 N. BROADWAY BALTIMORE, MD. 21231</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>Dec. 13 1982</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer</b>		23d. LOCATION CITY OR TOWN <b>BALTO.</b>	STATE <b>MD.</b>
24. FUNERAL DIRECTOR NAME <b>DELLA NOCE AND SONS</b>		ADDRESS <b>3425 N. High St</b>		25a. DATE REC'D. BY REGISTRAR <b>DEC 13 1982</b>	
				25b. REGISTRAR'S SIGNATURE <b>John J. Smith</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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DEC 18 1985  
J. S. G. Smith

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 3 1 9 7 0			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>MILTON FRANK TRUSZKOWSKI</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>12 3 82</b>		2b. HOUR <b>5:58P</b> M	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>12 2 1925</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>57</b> YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>VAMC, BALTIMORE, MARYLAND 21218</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Electrician</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Beth. Steel</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Dundalk</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Frank Truszkowski</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Stella Bonus</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>Yes WW II</b>			
16b. SOCIAL SECURITY NO. <b>212-20-0095</b>		17. INFORMANT ADDRESS <b>660 Charante Ct. 21061</b> <b>Toni M. Truszkowski Glen Burnie, MD.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>5728 IMMEDIATE CAUSE (a) CARDIAC ARREST</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>MASSIVE GASTRO-INTESTINAL hemorrhage</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>end-STAGE Liver failure</b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>November 26, 1982</b> , to <b>December 3, 1982</b> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <b>December 3, 1982</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) <input checked="" type="checkbox"/> (not) view the body after death.							
22b. SIGNATURE <b>Richard S. Phillips</b>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>12-3-82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Richard Phillips</b>				22e. ADDRESS <b>VAMC, Baltimore, Maryland 21218</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>12/7/1982</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Green Mount</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Maryland</b>	
24. FUNERAL DIRECTOR NAME <b>Duda-Ruck, Inc.</b> ADDRESS <b>7922 Wise Avenue Dundalk, MD. 21222</b>				25a. DATE REC'D. BY REGISTRAR <b>DEC 9 - 1982</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

Form with multiple sections and fields, including a header area with a date field and a large table area with multiple rows and columns. The text is faint and mostly illegible.



100% COTTON



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 2 3 1 9 7 1	
1. FOR STATE REGISTRAR				REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Ary TURNER			2a. DATE OF DEATH MONTH DAY YEAR December 4, 1982		2b. HOUR 11:15P M
3. SEX Female	4. RACE Col. ✓	5. DATE OF BIRTH MONTH DAY YEAR 6-26-1892	6. AGE (IN YEARS LAST BIRTHDAY) 90 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Shallowell (b.)	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.		
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Maryland General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Hemophiler		12b. KIND OF BUSINESS OR INDUSTRY —
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE MIDDLE COUNTY 13b. CITY OR TOWN Baltimore			13c. STREET ADDRESS 2130 W. Fayette St		
14. FATHER'S NAME Obediack			15. MOTHER'S MAIDEN NAME Kato Mosby		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. Briff		17. INFORMANT ADDRESS Mr. Sylvan Fleming 7254 Rose Rd	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 2050 IMMEDIATE CAUSE (a) <u>Acute Myelogenous Leukemia</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1978-1982
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE	
22a. I certify that (I or this hospital) attended the deceased from <u>November 23</u> , 19 <u>82</u> , to <u>December 4</u> , 19 <u>82</u> , the <u>XX</u> (we) lost saw the deceased alive on above <u>XX</u> (we) (did) <u>not</u> view the body after death.					
22b. SIGNATURE Tommy T. Hsu M.D.		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 12/4/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Tommy T. Hsu, M.D.		22e. ADDRESS c/o Maryland General Hospital			
23a. BURIAL, CREMATION, REMOVAL (BY) BURIAL	23b. DATE 12-9-82	23c. NAME OF CEMETERY OR CREMATORY SAINT'S REST	23d. LOCATION CITY OR TOWN COUNTY STATE NORMAN A. D. C. MD		
24. FUNERAL DIRECTOR NAME JOSEPH L. RUSSELL		24b. ADDRESS 21224 NORTH AVE		25a. DATE REC'D. BY REGISTRAR DEC 13 1982	
		25b. REGISTRAR'S SIGNATURE John J. Canfield			





10/11/1912

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 3 1 9 7 2

FOR  
1 - STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>RALPH P. TURNER</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>DECEMBER 28, 1982</b>		2b. HOUR <b>3:35</b> A M					
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Sept 23 1961</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>21</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.				
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>THE JOHNS HOPKINS HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>CLERK</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Gov.</b>		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>			13b. COUNTY <b>Carroll</b>		13c. CITY OR TOWN <b>Manchester</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>2606 MINDI COURT</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Ralph V. Turner</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Anna S. Weatherholtz</b>			16. ADDRESS <b>2606 MINDI CT.</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>			16b. SOCIAL SECURITY NO. <b>215-74-8177</b>		17. INFORMANT <b>Anna S. Turner Manchester, Md 21122</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: <b>2770 IMMEDIATE CAUSE (a) respiratory arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>severe pulmonary compromise, recurrent infections</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>cystic fibrosis</b> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LOST. <b>minutes</b> <b>several days</b> <b>since birth</b>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>none</b>										
19a. DATE OF OPERATION <b>-</b>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>-</b>			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>NO</b>			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) <b>-</b>				
21d. INJURY OCCURRED <b>NO</b> WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <b>-</b>			21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>-</b>				
22a. I certify that (I) (this hospital) attended the deceased from <b>12/24</b> , 19 <b>82</b> , to <b>12/28</b> , 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>12/28</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>LW Martin MD</b>			DEGREE <b>MD</b>				22c. DATE SIGNED <b>12/28/82</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>LW Martin</b>			22e. ADDRESS <b>Johns Hopkins Hospital, 600 N Broadway St Baltimore Md 21205</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>12/31/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Great Lawn Mem. Gardens, Manassasville, Howard, Md.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE			
24. FUNERAL DIRECTOR NAME <b>H. J. Eckhardt</b>			ADDRESS <b>Manchester, Md.</b>			25a. DATE REC'D. BY REGISTRAR <b>JAN 3 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Conner</b>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 10 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DATE	NAME	ADDRESS	CITY	STATE	ZIP
1/1/50	John Doe	123 Main St	New York	NY	10001
1/1/50	Jane Smith	456 Elm St	Los Angeles	CA	90001
1/1/50	Bob Johnson	789 Oak St	Chicago	IL	60601
1/1/50	Alice Brown	101 Pine St	San Francisco	CA	94101
1/1/50	Frank White	202 Cedar St	Philadelphia	PA	19101
1/1/50	Grace Green	303 Birch St	Boston	MA	02101
1/1/50	Henry Black	404 Spruce St	Seattle	WA	98101
1/1/50	Irene Grey	505 Willow St	Portland	OR	97201
1/1/50	Jack Blue	606 Ash St	San Diego	CA	92101
1/1/50	Karen Red	707 Hickory St	Denver	CO	80201
1/1/50	Leo Yellow	808 Sycamore St	San Jose	CA	95101
1/1/50	Mary Purple	909 Magnolia St	San Antonio	TX	78201
1/1/50	Ned Brown	1010 Poplar St	San Jose	CA	95101
1/1/50	Olivia Green	1111 Walnut St	San Jose	CA	95101
1/1/50	Peter Blue	1212 Chestnut St	San Jose	CA	95101
1/1/50	Quinn Red	1313 Elm St	San Jose	CA	95101
1/1/50	Rachel Yellow	1414 Oak St	San Jose	CA	95101
1/1/50	Samuel Purple	1515 Pine St	San Jose	CA	95101
1/1/50	Tina Grey	1616 Cedar St	San Jose	CA	95101
1/1/50	Victor Blue	1717 Birch St	San Jose	CA	95101
1/1/50	Wendy Red	1818 Spruce St	San Jose	CA	95101
1/1/50	Xavier Yellow	1919 Willow St	San Jose	CA	95101
1/1/50	Yvonne Purple	2020 Ash St	San Jose	CA	95101
1/1/50	Zoe Grey	2121 Hickory St	San Jose	CA	95101
1/1/50	Adam Blue	2222 Sycamore St	San Jose	CA	95101
1/1/50	Bella Red	2323 Magnolia St	San Jose	CA	95101
1/1/50	Charlie Yellow	2424 Poplar St	San Jose	CA	95101
1/1/50	Diana Purple	2525 Walnut St	San Jose	CA	95101
1/1/50	Ethan Grey	2626 Chestnut St	San Jose	CA	95101
1/1/50	Fiona Blue	2727 Elm St	San Jose	CA	95101
1/1/50	Gavin Red	2828 Oak St	San Jose	CA	95101
1/1/50	Helen Yellow	2929 Pine St	San Jose	CA	95101
1/1/50	Ian Purple	3030 Cedar St	San Jose	CA	95101
1/1/50	Jessica Grey	3131 Birch St	San Jose	CA	95101
1/1/50	Kyle Blue	3232 Spruce St	San Jose	CA	95101
1/1/50	Laura Red	3333 Willow St	San Jose	CA	95101
1/1/50	Mason Yellow	3434 Ash St	San Jose	CA	95101
1/1/50	Natalie Purple	3535 Hickory St	San Jose	CA	95101
1/1/50	Oscar Grey	3636 Sycamore St	San Jose	CA	95101
1/1/50	Pamela Blue	3737 Magnolia St	San Jose	CA	95101
1/1/50	Quinn Red	3838 Poplar St	San Jose	CA	95101
1/1/50	Rachel Yellow	3939 Walnut St	San Jose	CA	95101
1/1/50	Samuel Purple	4040 Chestnut St	San Jose	CA	95101
1/1/50	Tina Grey	4141 Elm St	San Jose	CA	95101
1/1/50	Victor Blue	4242 Oak St	San Jose	CA	95101
1/1/50	Wendy Red	4343 Pine St	San Jose	CA	95101
1/1/50	Xavier Yellow	4444 Cedar St	San Jose	CA	95101
1/1/50	Yvonne Purple	4545 Birch St	San Jose	CA	95101
1/1/50	Zoe Grey	4646 Spruce St	San Jose	CA	95101
1/1/50	Adam Blue	4747 Willow St	San Jose	CA	95101
1/1/50	Bella Red	4848 Ash St	San Jose	CA	95101
1/1/50	Charlie Yellow	4949 Hickory St	San Jose	CA	95101
1/1/50	Diana Purple	5050 Sycamore St	San Jose	CA	95101
1/1/50	Ethan Grey	5151 Magnolia St	San Jose	CA	95101
1/1/50	Fiona Blue	5252 Poplar St	San Jose	CA	95101
1/1/50	Gavin Red	5353 Walnut St	San Jose	CA	95101
1/1/50	Helen Yellow	5454 Chestnut St	San Jose	CA	95101
1/1/50	Ian Purple	5555 Elm St	San Jose	CA	95101
1/1/50	Jessica Grey	5656 Oak St	San Jose	CA	95101
1/1/50	Kyle Blue	5757 Pine St	San Jose	CA	95101
1/1/50	Laura Red	5858 Cedar St	San Jose	CA	95101
1/1/50	Mason Yellow	5959 Birch St	San Jose	CA	95101
1/1/50	Natalie Purple	6060 Spruce St	San Jose	CA	95101
1/1/50	Oscar Grey	6161 Willow St	San Jose	CA	95101
1/1/50	Pamela Blue	6262 Ash St	San Jose	CA	95101
1/1/50	Quinn Red	6363 Hickory St	San Jose	CA	95101
1/1/50	Rachel Yellow	6464 Sycamore St	San Jose	CA	95101
1/1/50	Samuel Purple	6565 Magnolia St	San Jose	CA	95101
1/1/50	Tina Grey	6666 Poplar St	San Jose	CA	95101
1/1/50	Victor Blue	6767 Walnut St	San Jose	CA	95101
1/1/50	Wendy Red	6868 Chestnut St	San Jose	CA	95101
1/1/50	Xavier Yellow	6969 Elm St	San Jose	CA	95101
1/1/50	Yvonne Purple	7070 Oak St	San Jose	CA	95101
1/1/50	Zoe Grey	7171 Pine St	San Jose	CA	95101
1/1/50	Adam Blue	7272 Cedar St	San Jose	CA	95101
1/1/50	Bella Red	7373 Birch St	San Jose	CA	95101
1/1/50	Charlie Yellow	7474 Spruce St	San Jose	CA	95101
1/1/50	Diana Purple	7575 Willow St	San Jose	CA	95101
1/1/50	Ethan Grey	7676 Ash St	San Jose	CA	95101
1/1/50	Fiona Blue	7777 Hickory St	San Jose	CA	95101
1/1/50	Gavin Red	7878 Sycamore St	San Jose	CA	95101
1/1/50	Helen Yellow	7979 Magnolia St	San Jose	CA	95101
1/1/50	Ian Purple	8080 Poplar St	San Jose	CA	95101
1/1/50	Jessica Grey	8181 Walnut St	San Jose	CA	95101
1/1/50	Kyle Blue	8282 Chestnut St	San Jose	CA	95101
1/1/50	Laura Red	8383 Elm St	San Jose	CA	95101
1/1/50	Mason Yellow	8484 Oak St	San Jose	CA	95101
1/1/50	Natalie Purple	8585 Pine St	San Jose	CA	95101
1/1/50	Oscar Grey	8686 Cedar St	San Jose	CA	95101
1/1/50	Pamela Blue	8787 Birch St	San Jose	CA	95101
1/1/50	Quinn Red	8888 Spruce St	San Jose	CA	95101
1/1/50	Rachel Yellow	8989 Willow St	San Jose	CA	95101
1/1/50	Samuel Purple	9090 Ash St	San Jose	CA	95101
1/1/50	Tina Grey	9191 Hickory St	San Jose	CA	95101
1/1/50	Victor Blue	9292 Sycamore St	San Jose	CA	95101
1/1/50	Wendy Red	9393 Magnolia St	San Jose	CA	95101
1/1/50	Xavier Yellow	9494 Poplar St	San Jose	CA	95101
1/1/50	Yvonne Purple	9595 Walnut St	San Jose	CA	95101
1/1/50	Zoe Grey	9696 Chestnut St	San Jose	CA	95101
1/1/50	Adam Blue	9797 Elm St	San Jose	CA	95101
1/1/50	Bella Red	9898 Oak St	San Jose	CA	95101
1/1/50	Charlie Yellow	9999 Pine St	San Jose	CA	95101

11-2-50  
 11-2-50  
 11-2-50

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 4 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 48 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>PERCY</b>										2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 12 18 19 82	
3. SEX <b>male</b> 4. RACE <b>Black</b> 5. DATE OF BIRTH MONTH DAY YEAR <b>5 14 48</b> 6. AGE (IN YEARS) LAST BIRTHDAY <b>34 YRS.</b> 7. IF UNDER 1 YR. MONTHS DAYS 7b. IF UNDER 24 HRS. HOURS MIN.										7c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>12 19 19 82</b> 7d. HOUR <b>12:35 aM</b>	
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>			9. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			10. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.		
10. CITY OR TOWN OF DEATH <b>Baltimore</b>			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>1615 E. 29th St.</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE <b>Maryland</b>			13b. COUNTY			13c. CITY OR TOWN <b>Baltimore</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS <b>1615 E. 29th Street 21218</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Percy</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Delores Dotson</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. <b>216-50-4770</b>			17. INFORMANT ADDRESS <b>Dolores B. Dotson 2803 Boarman Avenue</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Intravenous narcotism</b> <b>3049</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ (c) _____ PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <i>Ann M. Dixon</i>			TITLE (SPECIFY) M.D. <b>Assistant</b> MEDICAL EXAMINER					DATE SIGNED <b>12-19-82</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>Ann M. Dixon, M.D.</b>			ADDRESS <b>111 Penn St., Balto., Md. 21201</b>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b. DATE <b>12/28/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arbutus Mem. Pk.</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Arbutus Md.</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>Wm. C. March F/H Inc. 1101 E. North Avenue</b>						25a. DATE REC'D BY REGISTRAR <b>DEC 22 1982</b> REGISTRAR'S SIGNATURE <i>John J. Conner</i>					

9304 MO TO

WIND



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 3 1 9 7 4

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Lillian Johnson Tyler			2a. DATE OF DEATH MONTH DAY YEAR 12 12 82			2b. HOUR 8:50 PM			
3 SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 07 13 02		6. AGE (IN YEARS LAST BIRTHDAY) 80			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 6225 York Road			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Food Handler		12b. KIND OF BUSINESS OR INDUSTRY School		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST James Johnson			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Estelle Chase						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No			16b. SOCIAL SECURITY NO. 215-18-3896A		17. INFORMANT ADDRESS 1823 Rambling Ridge Lane Irma Tyler-Baltimore, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Auto CVA</u> 4360 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hrs.		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>7/14</u> , 19 <u>82</u> , to <u>12/12</u> , 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>12/6</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE E. Lee Robbins MD						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/14/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) E. Lee Robbins MD						22e. ADDRESS 1205 York Rd. Lutherville Md. 21093			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 12/16/82		23c. NAME OF CEMETERY OR CREMATORY Arbutus Mem. Park		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Co., MD		
24. FUNERAL DIRECTOR NAME Harbert E. Hutter 3035 W. NORTH AVE.						25a. DATE REC'D. BY REGISTRAR DEC 17 1982		25b. REGISTRAR'S SIGNATURE John J. Conner	

BP

2768





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 18 is marked or item 19 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 4/82  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 3 1 9 7 5

1. FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Victoria E. Tyler</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>12/13/82</b>			2b. HOUR <b>6<sup>56</sup> PM</b>	
3. SEX <b>Female</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>04 17 98</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>84</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Balti. City</b> MD.	
10. CITY OR TOWN OF DEATH <b>Balti.</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>University of Md Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
13a. STATE <b>MD</b>		13b. COUNTY <b>Balti.</b>		13c. CITY OR TOWN <b>Balti.</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>John Y Tyler</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Candyn Fran ce Rawlings</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. <b>212-32-3658</b>	
17. INFORMANT NAME ADDRESS <b>Miss Paula Tyler 4003 Hayward Ave.</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>1889</b> IMMEDIATE CAUSE (a) <b>Acute Renal Failure</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Bladder Cancer and obstruction</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Bladder Cancer and obstruction</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>11d</b>		PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>12/12</b> , 19 <b>82</b> , to <b>12/13</b> , 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>12/13</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Robert H. Leutz MD</b>		DEGREE		22c. DATE SIGNED <b>12/13/82</b>		22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Robert H. Leutz</b>	
22e. ADDRESS <b>University Hospital</b>		22f. ADDRESS		22g. ADDRESS		22h. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>12-17-82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arbutus</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTO Md</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>JAMES A. MORTON &amp; SONS - 1701 LAURENS</b>		25a. DATE REC'D. BY REGISTRAR <b>DEC 15 1982</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Canine</b>			

NO



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 2 3 1 9 7 6			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) JOHN L. ULBRICH				2a. DATE OF DEATH MONTH DAY YEAR 12 28 82			
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 06 12 15		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1939 W. Lombard Street		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) MACHINIST		12b. KIND OF BUSINESS OR INDUSTRY CANDY CO.	
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
13a. STATE MARYLAND		13b. COUNTY ---		13c. CITY OR TOWN BALTIMORE		13e. STREET ADDRESS 1939 W. LOMBARD STREET, 21223	
14. FATHER'S NAME FIRST MIDDLE LAST WILLIAM ULBRICH				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LOUISE UNKNOWN			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 216-05-7230		17. INFORMANT ADDRESS NORMAN C. ULBRICH 4705 OLD HANOVER ROAD WESTMINSTER, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute coronary occlusion</u> DUE TO, OR AS A CONSEQUENCE OF <u>STATUS POST STROKE, MYOCARDIAL INFARCTION</u> (b) <u>ASCVD - coronary heart disease</u> DUE TO, OR AS A CONSEQUENCE OF <u>ASCVD - coronary heart disease</u> (c) <u>old age, atherosclerosis</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u> <u>years</u> <u>years</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE STREET			
22a. I certify that (I) (this hospital) attended the deceased from <u>Oct. 6, 1979</u> to <u>Dec 28</u> , 19 <u>82</u> , that (I) (we) lost saw the deceased alive on <u>Dec 28</u> 19 <u>82</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (they) did not view the body after death.							
22b. SIGNATURE <u>Henry Armanas</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>Dec 29/82</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Henry Armanas, MD.				22e. ADDRESS 1934 Wilkens Avenue			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE 12-31-82		23c. NAME OF CEMETERY OR CREMATORY LOUDON PARK		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE CITY MARYLAND	
24. FUNERAL DIRECTOR NAME HUBBARD FUNERAL HOME, INC.		ADDRESS 21229 4107 WILKENS AVE.		25a. DATE REC'D. BY REGISTRAR DEC 30 1982		25b. REGISTRAR'S SIGNATURE <u>John J. Cahill</u>	

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST BRUCE			MIDDLE N. EIL			LAST ULLMAN			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 12-19-82			2b. HOUR M				
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR JULY 14, 1958		6. AGE (IN YEARS) LAST BIRTHDAY 24 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD 12-19-82			2d. HOUR 3:30 P				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD							
10. CITY OR TOWN OF DEATH Baltimore				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) University Hospital S.T.U.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SELF-EMPLOYED				12b. KIND OF BUSINESS OR INDUSTRY VENDING							
13a. STATE MARYLAND				13b. COUNTY BALTO.				13c. CITY OR TOWN BALTIMORE				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				13e. STREET ADDRESS 6848 WESTRIDGE RD. #21207			
14. FATHER'S NAME FIRST MIDDLE LAST DONALD ULLMAN								15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LINDA BESSIN											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO				(IF YES, GIVE WAR OR DATES)				16b. SOCIAL SECURITY NO. 212-76-5712				17. INFORMANT DONALD ULLMAN APT. 102 103 FITZ CT. REISTERSTOWN, MD 21136							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 9554 IMMEDIATE CAUSE (a) Gunshot wound of head DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)																APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?												20. AUTOPSY? (HEAD ONLY) YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 4:35AM 12-17-82				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) self/inflicted											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) parking lot				21f. LOCATION STREET CITY OR TOWN COUNTY STATE 8212 Liberty Road Baltimore Co., Maryland											
22a. I certify that I took charge of the remains (HEAD ONLY) in Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																			
ACTUAL SIGNATURE <i>Margarita A. Koroll</i>				TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER				DATE SIGNED 12-20-82											
EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Koroll, M.D.				ADDRESS 111 Penn Street															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL				23b. DATE DEC. 21, 1982				23c. NAME OF CEMETERY OR CREMATORY HAR SINAI				23d. LOCATION CITY OR TOWN COUNTY STATE OWINGS, MILLS BALTO. MD							
24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC.				ADDRESS 6010 REISTERSTOWN RD. BALTO., MD 21215				25a. DATE REC'D BY REGISTRAR DEC 28 1982				25b. REGISTRAR'S SIGNATURE <i>J. C. G. G. G.</i>							

No.		Date		Description		Amount	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

12  
1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) George William Ulrich			2a. DATE OF DEATH MONTH DAY YEAR 12 22 82			2b. HOUR 1:30 P.M.			
3. SEX male		4. RACE Cauc.		5. DATE OF BIRTH MONTH DAY YEAR 12 20 08		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
8a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md. U.S.A.		8b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SBGH				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Chart Room Ret.		12b. KIND OF BUSINESS OR INDUSTRY Essex.	
13a. STATE MD		13b. COUNTY AA		13c. CITY OR TOWN Gen Burnie		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 305 Oxford Dr.	
14. FATHER'S NAME FIRST MIDDLE LAST George William Ulrich				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Minnie Berger					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) UNKNOWN NO				16b. SOCIAL SECURITY NO. 219-05-5287		17. INFORMANT S. Giles M.D. SBGH			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4100 IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cardiogenic Shock</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Acute Myocardial Infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Insulin dependent diabetes mellitus</u>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>12/22</u> , 19 <u>82</u> , to <u>12/22</u> , 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>12/22</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death.									
22b. SIGNATURE <u>S. Giles MD</u>			DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 12/22/82		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Steven Giles MD				22e. ADDRESS SBGH.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) ENTOMBMENT			23b. DATE 12-27-82		23c. NAME OF CEMETERY OR CREMATORY Lorraine Park		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.		
24. FUNERAL DIRECTOR NAME ZANUINO FUN. Home-263 S. CONKLING ST.				25a. DATE REC'D. BY REGISTRAR DEC 27 1982		25b. REGISTRAR'S SIGNATURE John J. Connelley			

BP





DEC 27 1983  
J. J. Smith

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 300-3125.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 3 1 9 7 9

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <i>Stevenson Earle Umberger Jr.</i> <i>STEVENSON UMBERGER</i>		2a. DATE OF DEATH MONTH <i>12</i> DAY <i>30</i> YEAR <i>82</i>		2b. HOUR <i>6 52</i> AM	
3. SEX <i>Male</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH <i>11</i> DAY <i>24</i> YEAR <i>30</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>West Virginia</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>52</i> YRS.	
10. CITY OR TOWN OF DEATH <i>Baltimore</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Baltimore City Hospitals</i>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City</i> MD.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Welder</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Beth. Steel</i>			
13a. STATE <i>Maryland</i>		13b. COUNTY <i>Baltimore</i>		13c. CITY OR TOWN <i>Baltimore</i>	
14. FATHER'S NAME FIRST <i>Stevenson</i> MIDDLE <i>Earle</i> LAST <i>Umberger Sr.</i>		15. MOTHER'S MAIDEN NAME FIRST <i>Ethel</i> MIDDLE <i>May</i> LAST <i>Pettrey</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. <i>232-74-2210</i>		17. INFORMANT <i>Betty D. Umberger</i> ADDRESS <i>3920 Hudson Street 21224</i>	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac Arrest</i> <i>4275</i> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO, OR AS A CONSEQUENCE OF PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a <i>Sepsis</i>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18; PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) (this hospital) attended the deceased from <i>12/29</i> 19 <i>82</i> to <i>12/30</i> 19 <i>82</i> , that (1) (we) last saw the deceased alive on <i>12/30</i> 19 <i>82</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Signature</i>		DEGREE		22c. DATE SIGNED <i>12/30/82</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Cremation</i>		23b. DATE <i>1-1-83</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Westview Crematorium</i>	
23d. LOCATION CITY OR TOWN COUNTY STATE <i>Westview, Balto Co., Md.</i>		24. FUNERAL DIRECTOR NAME <i>C.S. Zeiler &amp; Son Inc.</i> ADDRESS <i>901 S. Conkling Street</i>			
25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <i>John J. Connel</i>			

MEDICAL CERTIFICATION

2  
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BP

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Station Code 110000

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STATE OF MARYLAND  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 CERTIFICATE OF DEATH

8 2 3 1 9 8 0

 1- FOR  
 STATE  
 REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR	
ROBERTA		UR		QUHART				12		28	82	8:25AM		
3 SEX		4 RACE		5. DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS				
Female		Col		7-2-1896		86		MONTHS		DAYS		HOURS MIN.		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH								
N.C.		U.S.A.				Baltimore City						MD.		
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY								
BALTIMORE CITY		PROVIDENT HOSPITAL		Homemaker										
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b STATE		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS						
Maryland				BALTO.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		2223 Pulaski ST						
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME												
Weldon		Lucy												
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO.		17 INFORMANT		ADDRESS								
NO		165-10-64120		Mr. Weldon Ford		2910 Keyworth Ave.								
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
2501		cardioRespiratory arrest		Sepsis Shock										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		(b)		(c)										
				Diabetic Ketoacidosis										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?								
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)										
		P.M. 19												
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE				
22a I certify that (I) (this hospital) attended the deceased from 12-28-82 to 12-28-82, that (I) (we) last saw the deceased alive on 12-28-82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE		DEGREE		22c. DATE SIGNED								
		SHER AFZAL HASHMI MD		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		12-28-82								
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS												
SHER AFZAL HASHMI		PROVIDENT HOSPITAL BALTIMORE MD												
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (CITY OR TOWN)		COUNTY		STATE				
Burial		12-31-82		Mt. Zion Cem.		Lansdowne		MD.						
24 FUNERAL DIRECTOR NAME		24b. ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE								
Joseph L. Russ		2222 W. North Ave.		JAN 4 1983		John J. Conner								

 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
 IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Handwritten text, likely a letter or document, written in cursive. The text is mostly illegible due to fading and bleed-through from the reverse side. Some legible fragments include "Dear Sir", "I have the honor", and "Yours very truly".

Handwritten text at the bottom of the page, possibly a signature or a closing. It appears to be "Yours very truly" followed by a signature.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 3 1 9 8 1

1 - FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MARY MIDDLE Anna LAST VADEN			2a. DATE OF DEATH MONTH DAY YEAR DEC. 22 1982		2b. HOUR 5:45 PM
3. SEX F female	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR 7 24 1910		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia	7b. CITIZEN OF WHAT COUNTRY? US	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH BALTO. MD	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SOUTH BALTO GEN. HOSP.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife	12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MD.	13b. CITY OR TOWN BALTO	13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13d. STREET ADDRESS 205 W. MEADOW RD (PEATON MED CTR. S CHARL)		
14. FATHER'S NAME FIRST MIDDLE LAST James Edward Shanks		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Marjorie Lee Caldwell			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 220 24 1971		17. INFORMANT ADDRESS 21224 Virginia E. Brown, 7009 Bank St., Baltimore, Md	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SEPSIS 4360 DUE TO, OR AS A CONSEQUENCE OF (b) ASPIRATION PNEUMONIA & URINARY TRACT INFECTION DUE TO, OR AS A CONSEQUENCE OF (c) BILATERAL CEREBRO-VASCULAR ACCIDENT 4mons					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) DIABETES MELITUS, UPPER GASTRO-INTESTINAL BLEEDING					
19a. DATE OF OPERATION NONE	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED NA	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. NA 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) NA			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) NA	21f. LOCATION STREET CITY OR TOWN COUNTY STATE NA			
22a. I certify that (I) (this hospital) attended the deceased from DEC. 20, 19 82, to DEC. 22, 19 82, that (I) (we) last saw the deceased alive on DEC. 20, 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Florante Richard Mancao		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED DEC. 22, 1982	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) FLORANTE RICHARD MANCAO		22e. ADDRESS SOUTH BALTO. GENERAL HOSPITAL			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 12/24/82	23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem. Pk.	23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie A.A.Co. Md.	23e. REC'D BY REGISTRAR 23f. REGISTRAR'S SIGNATURE DEC 28 1982 John J. Conner	
24. FUNERAL DIRECTOR NAME ADDRESS Gonce Funeral Home 4001 Ritchie Hwy. Balto. Md.					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Registrar of Death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of the death.



RENTAL MOTOR VEHICLES



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 31982	
1. DECEASED NAME (TYPE OR PRINT) <b>Larry Wayne Vehstedt</b>							2a. DATE KNOWN OF DEATH <b>XX</b> MONTH <b>12</b> DAY <b>21</b> YEAR <b>1982</b>		2b. HOUR <b>AM</b>		
1. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>Jan. 25, 1942</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>40</b> YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		2c. DATE PRONOUNCED DEAD <b>12 21 19 82</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Balto Co. Md.</b>			7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b>		
10. CITY OR TOWN OF DEATH <b>Baltimore</b>			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>University Hospital STU</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>St. of Md Montebello Hosp</b>			12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Md</b>		13b. COUNTY <b>Balto</b>		13c. CITY OR TOWN <b>Reisterstown</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>404 Suburban Court</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Henry Vehstedt</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Dorothy Owings</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. <b>212-40-0538</b>		17. INFORMANT ADDRESS <b>Mrs. Frances A. Vehstedt Reist.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: <b>Multiple injuries</b> <b>8147</b> IMMEDIATE CAUSE (a) <b>Multiple injuries</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) <b>Due to, or as a consequence of</b> (c) <b>Due to, or as a consequence of</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY <b>6:10AM 12/21 19 82</b>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) <b>pedestrian struck by vehicle</b>			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>roadway</b>				21f. LOCATION <b>12000BlkReisterstownRd, BaltoCo, Maryland</b>			
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <b>Accident</b> <input checked="" type="checkbox"/> Natural causes <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <b>H R Guard</b>				TITLE (SPECIFY) <b>M.D. Assistant</b>				DATE SIGNED <b>12/21/82</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>Hormez R. Guard, M.D.</b>				ADDRESS <b>111 Penn Street, Balto., MD 21201</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>				23b. DATE <b>Dec 24, 82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Security Process</b>			23d. LOCATION <b>Baltimore, Md.</b>		
24. FUNERAL DIRECTOR NAME <b>Eline Funeral Home</b>						ADDRESS <b>Reisterstown, Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>DEC 23 1982</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Gwinn</b>	

MEDICAL CERTIFICATION

RECEIVED  
FEDERAL BUREAU OF INVESTIGATION  
U. S. DEPARTMENT OF JUSTICE  
WASHINGTON, D. C. 20535

AL

RECEIVED  
FEDERAL BUREAU OF INVESTIGATION  
U. S. DEPARTMENT OF JUSTICE  
WASHINGTON, D. C. 20535



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove the bottom papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 3 1 9 8 3

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
IRVIN		VENEY		DECEMBER 3, 1982		10:50p	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR	
MALE	Col ✓	MONTH DAY YEAR AUG 1, 1934		48 YRS.		IF UNDER 24 HRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
VA	U.S.A.			BALTIMORE CITY MD.			
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
BALTIMORE	JOHNS HOPKINS HOSPITAL			TRUCK DRIVER		TRUCKING	

13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
MARYLAND				BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		533 MOSHER ST	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME							
FIRST MIDDLE LAST		FIRST MIDDLE LAST							
JOHN WASHINGTON		LENA VENIA BROOKS							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
NO		228 412 5387		Mrs ERNESTINE VENEY 533 Mosher St					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) <u>Hyperkalemia</u>			
1869 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute Renal Failure</u>		2 wks	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Metastatic Carcinoma of Testis</u>			

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: NO

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
11-12-82		Exploratory Laparotomy		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>11-14</u> , 19 <u>82</u> , to <u>12-3</u> , 19 <u>82</u> , that (I) (we) <input checked="" type="checkbox"/> lost saw the deceased alive on <u>12-3</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE <u>W. Morgan MD</u>		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 12-3-82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS					
W. Morgan MD		Johns Hopkins Hospital					

23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (CITY OR TOWN) COUNTY STATE	
BURIAL		12-7-82		MUNBERRY CEM		RICHMOND CO VA	
24. FUNERAL DIRECTOR <u>JOHN L. RICE 2220 W. NORTH AVE</u>				25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE DEC 13 1982 <u>John J. Conish</u>			

Long. 2.5

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 3 1 9 8 4

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>PAUL L VINCE</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>December 2, 1982</b>		2b. HOUR <b>6<sup>30</sup> PM</b>
3. SEX <b>MALE</b>	4. RACE <b>BLACK</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>3-17-30</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>52</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.		
10. CITY OR TOWN OF DEATH <b>Balto.</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Sinal Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Officer</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>State</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MARYLAND</b> 13b. COUNTY <b>Baltimore</b> 13c. CITY OR TOWN <b>Baltimore</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <b>4011 Bateman Ave</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Daniel Vince</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Florie Davis</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>216-24-5391</b>		17. INFORMANT ADDRESS <b>Florence Vince 4011 Bateman Ave.</b>	

## 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **Respiratory arrest**

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last

DUE TO, OR AS A CONSEQUENCE OF

(b) **Cancer of lung - poorly diff. Adenoc**

DUE TO, OR AS A CONSEQUENCE OF

**w/ ~~prob.~~ prob. repsis**

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH**immediate****3m**

## PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

**hyperosmolar state**

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>12-2</b> , 19 <b>82</b> , to <b>12-2</b> , 19 <b>82</b> , that (I) <del>(was)</del> lost saw the deceased alive on <b>12-2</b> , 19 <b>82</b> , and that in (my) <del>(own)</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>(was)</del> (did) <del>(not)</del> view the body after death.					
22b. SIGNATURE <b>Sheila Stalker</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>12-2-82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Sheila WALKER MD</b>		22e. ADDRESS <b>4419 FALLS Road Baltimore, Md 21211</b>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>12-6-82</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cmty.</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Md.</b>
24. FUNERAL DIRECTOR NAME <b>Ronald D. Collick</b>		ADDRESS <b>2431 E. Oliver St.</b>	25a. DATE REC'D. BY REGISTRAR <b>DEC 8 1982</b>
		25b. REGISTRAR'S SIGNATURE <b>John J. Canfield</b>	

THE UNIVERSITY OF CHICAGO  
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Daniel  
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BRUNEL 12-6-82  
BRUNEL 12-6-82  
BRUNEL 12-6-82



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										
8 2 3 1 9 8 5										
FOR 1 - STATE REGISTRAR										
CERTIFICATE OF DEATH										
REG. NO.										
1 DECEASED NAME (TYPE OR PRINT) <b>ALMA J. VINCK</b>					2a DATE OF DEATH MONTH DAY YEAR <b>12 5 82</b>					2b HOUR <b>7 09 pm</b>
3 SEX <b>Female</b>		4 RACE <b>Caucasian</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>March 27 1893</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>89</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>France</b>		7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.				
10 CITY OR TOWN OF DEATH <b>Baltimore</b>		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Good Samaritan Hosp</b>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b KIND OF BUSINESS OR INDUSTRY <b>-</b>		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										
13a STATE <b>Md.</b>		13b COUNTY <b>-</b>		13c CITY OR TOWN <b>Baltimore</b>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS <b>6401 Loch Raven Blvd.</b>		
14 FATHER'S NAME FIRST MIDDLE LAST <b>Jean Baptiste</b>					15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Celestine (unknown)</b>					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>					16b SOCIAL SECURITY NO. <b>215-34-8293</b>		17 INFORMANT ADDRESS <b>Edw. Vinck (son) 10 Weyfield Court</b>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										
PART I. DEATH WAS CAUSED BY.										
IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b>										
5860 DUE TO, OR AS A CONSEQUENCE OF (b) <b>METABOLIC ACIDOSIS</b>										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										
DUE TO, OR AS A CONSEQUENCE OF (c) <b>RENAL FAILURE</b>										
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
<b>9 MIN</b>										
<b>24 HOURS</b>										
<b>4 DAYS</b>										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)										
<b>HYPOTENSION, MYOCARDIAL INFARCTION</b>										
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (I) (this hospital) attended the deceased from <b>NOV 30</b> , 19 <b>82</b> , to <b>DEC 5</b> , 19 <b>82</b> that (I) (we) last saw the deceased alive on <b>DEC 5</b> , 19 <b>82</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.										
22b SIGNATURE <b>ST Kariya</b>					DEGREE <b>M.D.</b>			22c DATE SIGNED <b>12-5-82</b>		
22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>STEVEN T. KARIYA</b>					22e ADDRESS <b>JOHNS HOPKINS HOSP, BALTIMORE MD</b>					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b DATE <b>12/9/82</b>		23c NAME OF CEMETERY OR CREMATORY <b>Gardens of Faith</b>		23d LOCATION CITY OR TOWN COUNTY STATE <b>Balto. Md.</b>			
24 FUNERAL HOME NAME ADDRESS <b>Schimineck Funeral Home, Inc. 3331 Brehms Lane, Balto. Md. 21213</b>					25a DATE REC'D. BY REGISTRAR <b>DEC 7 - 1982</b>		25b REGISTRAR'S SIGNATURE <b>John J. Carver</b>			



100-7-1981

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE MEDICAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 WITH YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE RETURNED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 3 2 3 1 9 8 6	
1. DECEASED NAME (TYPE OR PRINT) <b>A/K/A Dominick</b> MIDDLE <b>DOMINIC</b> LAST <b>VITO</b>						2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> <b>12-3-82</b>		2b. HOUR <b>2PM</b>			
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>4/5/11/</b> MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY) <b>71</b> YRS.		7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN.			
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Balto. MD.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b>		10. DATE PRONOUNCED DEAD <b>12-3-82</b>			
11. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION <b>Union Memorial Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Unemployed</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <b>Maryland</b>		13b. COUNTY <b>City</b>		13c. CITY OR TOWN <b>City</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>3409 Kenyon Ave. 21213</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Nicholas Vito</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Aversa</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>yes</b>		16b. SOCIAL SECURITY NO. <b>WW II 217-12-6925</b>		17. INFORMANT ADDRESS <b>Marie L. Vito 3409 Kenyon Ave. 21213</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: <b>4292</b> IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held on death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE <b>H. R. Swaid</b>		TITLE (SPECIFY) <b>M.D. Assistant</b>				DATE SIGNED <b>12-4-82</b>					
EXAMINER'S NAME (TYPE OR PRINT) <b>Hormez R. Guard, M.D.</b>		ADDRESS <b>111 Penn Street</b>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>12/7/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore City Maryland</b>					
24. FUNERAL DIRECTOR NAME <b>Baltimore, Md. 21213</b>				25a. DATE RECEIVED BY REGISTRAR <b>DEC 7 - 1982</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Canish</b>					
Schimunek Funeral Home 3331 Brehms Ln.											

DEC 7 - 1982  
J. B. Smith

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be completed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use in the burial/transfer permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked on item 18, check any injury, or other traumatic event, the medical examiner will be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8	2	3	1	9	8	7
1. FOR STATE REGISTRAR										CERTIFICATE OF DEATH						
1. DECEASED NAME (TYPE OR PRINT)										2a. DATE OF DEATH						
FLORENCE G. VOMASTEK										12 01 82 11 58 AM						
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS				
FEMALE		CAUCASIAN		12 03 82			89 YRS.			MONTHS DAYS		HOURS MIN.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH									
Pa.		USA					CITY OF BALTIMORE MD.									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY				
BALTIMORE		SOUTH BALTIMORE GENERAL HOSP								HOUSEWIFE		HOME				
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS						
MD						BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		3402 Cardenas Ave. (21213)						
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME												
FRANK SNYDER				SALLIE HETTINGER												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS								
NO				216 20-8065		Dorothy Miller		201 Walton Ave. (21225)								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
PART I. DEATH WAS CAUSED BY:																
IMMEDIATE CAUSE (a) cardiopulmonary arrest										10 MIN						
4275 DUE TO, OR AS A CONSEQUENCE OF																
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last																
DUE TO, OR AS A CONSEQUENCE OF																
(c)																
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)																
GRADE III-IV TRANSITIONAL CELL CARCINOMA OF BLADDER																
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?								
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)												
		HOUR A.M. MONTH DAY YEAR														
		P.M. 19														
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION												
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK				STREET		CITY OR TOWN COUNTY STATE										
22a. I certify that (I) (this hospital) attended the deceased from 11-22-1982, to 12-1-1982, that (I) (we) last saw the deceased alive on 12-1-1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																
22b. SIGNATURE		DEGREE				22c. DATE SIGNED										
PETER H COOKE, MD						12-1-82										
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS														
PETER H COOKE		3001 S. HANOVER ST, BALTO														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		STATE								
Burial		12/4/82		Loudon Park Cem.		Baltimore		Md.								
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE										
George J. Gonce		DEC 6 - 1982				John J. Conish										
NAME		ADDRESS														
Balto., Md. 21225		4001 Ritchie Hgwy.														

29512 . 24 . 1910

885 - 0 330 . 500

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1. FOR STATE REGISTRAR		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>Joseph Francis Vyskocil</b>		2a. <b>12-24-82</b> MONTH DAY YEAR	
3. SEX <b>M Male</b>		2b. HOUR <b>1051 M</b>	
4. RACE <b>Caucasian</b>		5. DATE OF BIRTH <b>July 20, 1925</b>	
6. AGE (IN YEARS LAST BIRTHDAY) <b>57</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Baltimore, Md. USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City, MD.</b>	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Edgewood Nursing Home</b>	
12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Md.</b> 13b. COUNTY <b>--</b> 13c. CITY OR TOWN <b>Baltimore</b>		12b. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Bartender</b>	
14. FATHER'S NAME <b>Frank Vyskocil</b>		15. MOTHER'S MAIDEN NAME <b>Mary Van Meter</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b> (IF YES, GIVE WAR OR DATES) <b>WWII</b>		16b. SOCIAL SECURITY NO. <b>217-26-4173</b>	
17. INFORMANT <b>Baltimore, Md.</b>		18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b> 4275 DUE TO, OR AS A CONSEQUENCE OF (b) <b>4275</b> Conditions, if any, which gave rise to immediate cause (c) stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <b>4275</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. (a) <b>Diabetes. Peripheral Vascular Disease. Possible Posttraumatic Stress Disorder.</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 min.</b>	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (the hospital) attended the deceased from <b>11.7.82</b> 19 <b>82</b> to <b>12.24</b> 19 <b>82</b> , that (I) (we) lost <b>12.18.82</b> 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.		22b. SIGNATURE <b>[Signature]</b> DEGREE <b>MD</b>	
22c. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Dr. [Signature]</b>		22d. DATE SIGNED <b>12.27.82</b>	
22e. ADDRESS <b>3809 Greenmount Ave Balto 21218</b>		22f. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>12/28/82</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Parkwood Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Md.</b>	
24. FUNERAL DIRECTOR NAME <b>Schimunek Funeral Home</b>		25a. DATE REC'D. BY REGISTRAR <b>DEC 28 1982</b>	
25b. GISTRAR'S SIGNATURE <b>[Signature]</b>		25c. GISTRAR'S SIGNATURE <b>[Signature]</b>	

DEC 8 1983

John Smith



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 2 3 1 9 8 9  
CERTIFICATE OF DEATH

1. FOR STATE REGISTRAR			REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>SADIE S. WAGNER</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>DECEMBER 17, 1982</b>	
3. SEX <b>FEMALE</b>			2b. HOUR <b>1 A. M.</b>	
4. RACE <b>WHITE</b>			6. AGE (IN YEARS LAST BIRTHDAY) <b>78</b> YRS.	
5. DATE OF BIRTH MONTH DAY YEAR <b>NOV. 26, 1904</b>			8. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.	
7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>			10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>7231 PARK HTS. AVE., APT. B</b>	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSEWIFE</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>	
13a. STATE <b>MARYLAND</b>			13b. COUNTY <b>BALTIMORE</b>	
13c. CITY OR TOWN <b>BALTIMORE</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS <b>7231 PARK HTS. AVE. 21208</b>			13f. APT. B	
14. FATHER'S NAME FIRST MIDDLE LAST <b>SAMUEL SUGAR</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>ANNABELLE SACHS</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) <b>NO</b>			16b. SOCIAL SECURITY NO. <b>219-40-9514</b>	
17. INFORMANT <b>MRS. PHYLLIS BRILL</b>			18. ADDRESS <b>2302 SULGRAVE AVE. BALTO., MD 21209</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiorespiratory Arrest</b> <b>1830</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Ovarian Cancer</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <b>July 28, 1982</b> to <b>Dec 16, 1982</b> , that (I) (we) lost saw the deceased alive on <b>Oct 26, 1982</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (we) (we) saw the body after death.				
22b. SIGNATURE <b>Neil Rosensheim</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>12/17/82</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DR. NEIL ROSENSHEIM</b>		22e. ADDRESS <b>600 N. WOLF ST.</b>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>DEC. 19, 1982</b>		23c. NAME OF CEMETERY OR CREMATORY <b>CHIZUK AMUNO</b>
23d. LOCATION CITY OR TOWN <b>BALTIMORE</b>		23e. COUNTY <b>MARYLAND</b>		
24. FUNERAL DIRECTOR NAME <b>SOL LEVINSON &amp; BROS., INC.</b>		24a. DATE REC'D. BY REGISTRAR <b>DEC 21 1982</b>		
24b. ADDRESS <b>6010 REISTERSTOWN RD. BALTIMORE, MARYLAND 21215</b>		24c. REGISTRAR'S SIGNATURE <b>John J. Connel</b>		

MASSACHUSETTS

Sanctuary  
Sanctuary

2/1/91

Sanctuary



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 3 1 9 9 0

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>ALONZO WALKER</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>12-01-82</b>			2b. HOUR <b>120 p</b> M			
3 SEX <b>Male</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>11 08 06</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>76</b>		7. IF UNDER 1 YEAR MONTHS DAYS YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>City</b> MD.			
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Provident Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Fisherman</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>MD</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>3501 Fairview Ave-Apt B-1</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>John Alonzo Walker</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Ella Fallin</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>NO</b>				16b. SOCIAL SECURITY NO. <b>139-18-3980</b>		17. INFORMANT ADDRESS <b>Louise W. Brown</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <b>1629 IMMEDIATE CAUSE (a) Carcinoma of lungs &amp; Pleural metastases</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (b) <b>E. coli septicaemia suspected</b> DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Diabetic Keto Acidosis</b>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>11/25</b> , 19 <b>82</b> , to <b>12-1-</b> , 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>12-1-</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Franklin J. Addison, MD</b>					DEGREE <b>ATTENDING PHYSICIAN</b> <input type="checkbox"/> <b>MEDICAL DIRECTOR</b> <input checked="" type="checkbox"/> <b>STAFF PHYSICIAN</b> <input type="checkbox"/>		22c. DATE SIGNED <b>12/01/82</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>12/04/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Macedonia Baptist Church Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Northumberland Co., VA</b>		
24. FUNERAL DIRECTOR NAME ADDRESS <b>Herbert E. Nutter 3035 W. North Ave</b>					25. DATE REC'D. BY REGISTRAR <b>DEC 3-1982</b>		25. REGISTRAR'S SIGNATURE <b>John J. Cahill</b>		

10

THE UNITED STATES OF AMERICA

DEC 3 1953

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 3 1 9 9 1

FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>CALLIE WALKER</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>12 30 82</b>			2b. HOUR <b>450P</b>	
3. SEX <b>FEMALE</b>		4. RACE <b>NEGROID</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>12-25-12</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>65</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.	
10. CITY OR TOWN OF DEATH <b>BALTIMORE CITY</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>PROVIDENT HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>unemployed</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>md.</b>				13b. COUNTY <b>Balto.</b>		13c. STREET ADDRESS <b>371 Wilson St.</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Cleveland Walker</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Alice G. Parker</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>199-18-1766</b>		17. INFORMANT ADDRESS <b>GROVER Walker 1256 N. Broadway</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 2500 IMMEDIATE CAUSE (a) <b>cardiac Arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Renal Failure</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Diabetes Mellitus, CVA</b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>12-5-</b> 19 <b>82</b> , to <b>12-30</b> 19 <b>82</b> , that (I) (we) lost saw the deceased alive on <b>12-30</b> 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Sher Afzal Hashmi</b>				DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>12-30-82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>SHER AFZAL HASHMI</b>				22e. ADDRESS <b>PROVIDENT HOSPITAL BALTIMORE MD</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>1-4-83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Calvary Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Anne Arundel/Coos. md.</b>	
24. FUNERAL DIRECTOR NAME <b>Calvin B. SCRUGGS</b>				ADDRESS <b>1412 E. Preston</b>		25. DATE REC'D. BY REGISTRAR <b>4 1983</b>	
				26. REGISTRAR'S SIGNATURE <b>John J. Gurnea</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 4 and 2 should be kept within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 1B shows any injury, or other traumatic event, the medical examiner must be notified at once.





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 3 1 9 9 2

FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) (Drewery) Walker			2a. DATE OF DEATH MONTH DAY YEAR 12 16 82			2b. HOUR 10:22a			
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 12 12 35		6. AGE (IN YEARS LAST BIRTHDAY) 47 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City. MD.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Johns Hopkins Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Santee Walker			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bertha Watkins			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No			
16b. SOCIAL SECURITY NO. 225-38-8962			17. INFORMANT ADDRESS Sandis Hayspell PO BOX 241 Bradnox, Va.						

## 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

## PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) PULMONARY FAILURE

5185

DUE TO, OR AS A CONSEQUENCE OF

(b) PULMONARY FIBROSIS

DUE TO, OR AS A CONSEQUENCE OF

(c) ACUTE RESPIRATORY DISTRESS SYNDROME

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

6 weeks

10/10/82

## PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 12/14, 1982, to 12/16, 1982, that (I) (we) lost saw the deceased alive on 12/16, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Arthur N. Feldman MD, Ph.D.				DEGREE MD, Ph.D.		22c. DATE SIGNED 12/16/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Arthur N. Feldman				22e. ADDRESS Johns Hopkins Hospital			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 12/22/82		23c. NAME OF CEMETERY OR CREMATORY Church Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE South Hill Va.	
--------------------------------------------------------	--	-----------------------	--	-------------------------------------------------------	--	--------------------------------------------------------------	--

24. FUNERAL DIRECTOR NAME Wm. C. March F/H Inc. 1101 E. North Avenue		25a. DATE REC'D. BY REGISTRAR DEC 17 1982		25b. REGISTRAR'S SIGNATURE John J. Connel	
----------------------------------------------------------------------------	--	----------------------------------------------	--	----------------------------------------------	--

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4, reverse, retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as a burial permit. Then please remove and deposit with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition. If the death certificate is not filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition, the funeral director must be notified of this.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

BP

DHMH 16 50M 4/82

(VRA 15, 4)



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JAN 10 1961

RECEIVED  
JAN 10 1961

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

FOR Items 21athur 22a Film 575 1- STATE REGISTRAR 1-11-83 cn					STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 2 3 1 9 9 3 CERTIFICATE OF DEATH				
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH				
FIRST MIDDLE LAST					MONTH DAY YEAR HOUR				
ELEANOR B. WALKER					12 15 82 11:50 AM				
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7b. HOUR	
FEMALE		BLACK		8 MONTH DAY YEAR		57 YRS.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Md.		U.S.A.				BALTIMORE CITY MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
BALTO.		UNIVERSITY of Md. Shock Trauma				Unemployed			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13b. CITY OR TOWN		13c. STREET ADDRESS		
Md.					BALTO.		17 N. Amity St.		
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME				
FIRST MIDDLE LAST					FIRST MIDDLE LAST				
JOSEPH Y. ROBINSON					DAISY THOMPSON				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS		
NO					219-20-8898		Denise Walker 5310 Goodnow Rd. APT. H		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) Cardiac Arrhythmia / Failure									
8902									
DUE TO, OR AS A CONSEQUENCE OF (b) ARDS									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
DUE TO, OR AS A CONSEQUENCE OF (c) Carbon monoxide									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:									
Sepsis									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
-			-			YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
			HOUR A.M. MONTH DAY YEAR			House Fire			
			P.M. 12 4 1982						
21d. INJURY OCCURRED			21e. PLACE OF INJURY			21f. LOCATION		COUNTY STATE	
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			Home			STREET CITY OR TOWN		Baltimore Md	
22a. I certify that (I) (this hospital) attended the deceased from 12/4/82 to 12/15/82, that (I) (we) last saw the deceased alive on 12/15/82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. Accident									
22b. SIGNATURE								22c. DATE SIGNED	
Suzanne Wedel MD								12/15/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)								22e. ADDRESS	
Suzanne K. Wedel								MEMSS 22 S. Greene Balt. Md.	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		
Burial			12-20-82		Mt. Calvary Cem.		Anne Arundel County, Md.		
24. FUNERAL DIRECTOR					25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
NAME ADDRESS					DEC 6 1982		John J. Conner		
Calvin B. Scruggs 1712 E. Preston									

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WALKER

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unemployed

THOMAS

EASY

JEFF Y

NO

at the Davis Hall

at the Davis Hall  
at the Davis Hall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be required by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

Item 17 4575 1/6/83GAB  
FOR STATE REGISTRAR  
Item #14 Film G577  
3/21/83 rc

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

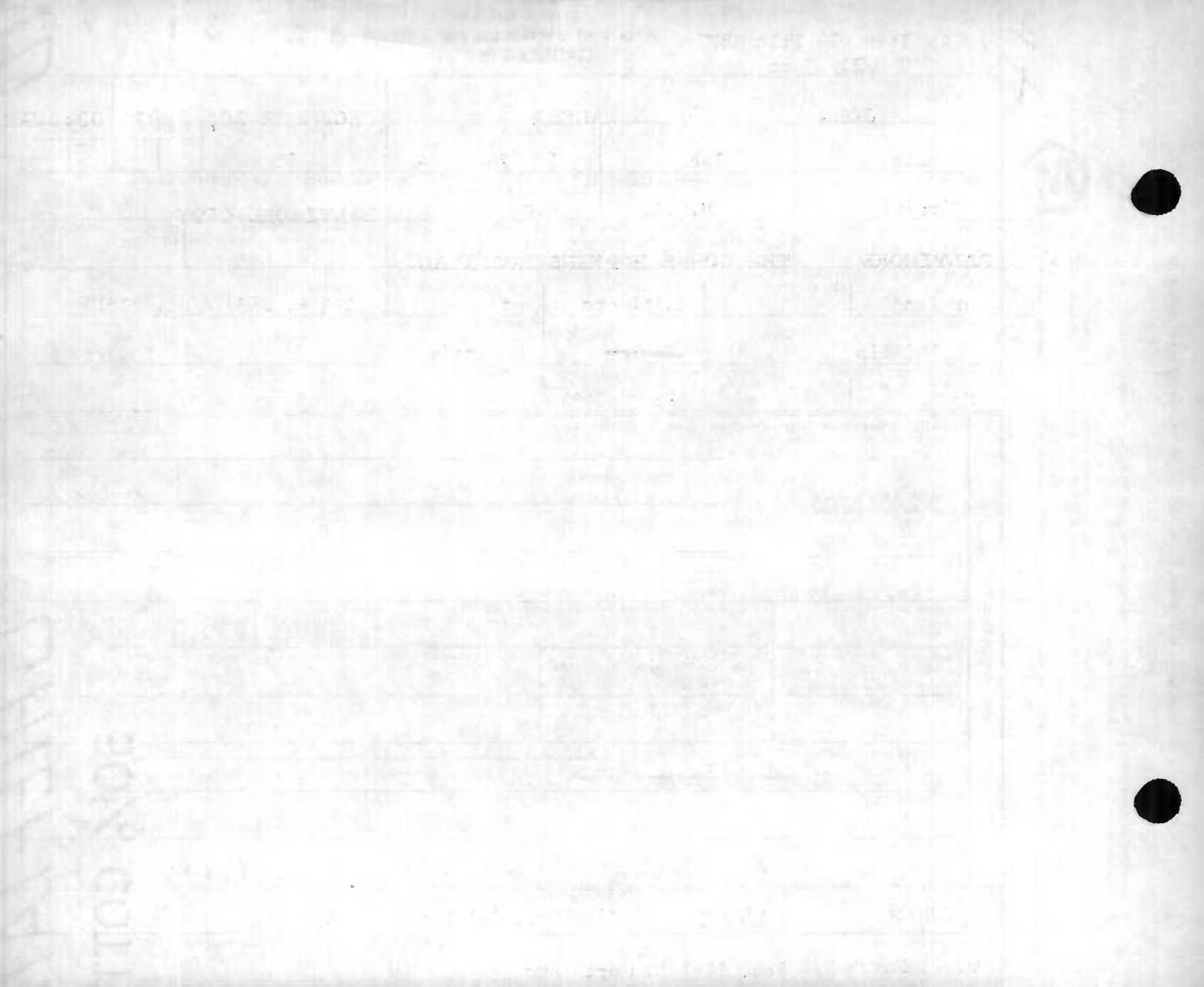
8 2 3 1 9 9 4

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) JOHN B. WALKER			2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 30, 1982			2b. HOUR 03:50AM	
3. SEX male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 3 24 04		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
12b. KIND OF BUSINESS OR INDUSTRY							
13a. STATE Maryland		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Phillip Walker Taylor		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mattie Fobers					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 213-09-3421		17. INFORMANT ADDRESS Claude Walker 2929 Linwood Ave.			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>respiratory arrest</u> 4860 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 min 2 week	
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a <u>congestive heart failure</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>12/29</u> , 19 <u>82</u> , to <u>12/30</u> , 19 <u>82</u> , that (I) (we) lost saw the deceased alive on <u>12/30</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Patricia A. Towers</u>				DEGREE MD		22c. DATE SIGNED 12-30-82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Patricia A. Towers</u>				22e. ADDRESS <u>601 N. Broadway Baltimore Md</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIAL) BURIAL		23b. DATE 1/4/83		23c. NAME OF CEMETERY OR CREMATORY King Memorial Park		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Co. Md.	
24. FUNERAL DIRECTOR NAME ADDRESS Wm. C. March F/H Inc. 1101 E. North Ave				25a. DATE REC'D. BY REGISTRAR JAN 4 1983		25b. REGISTRAR'S SIGNATURE <u>John J. Conner</u>	



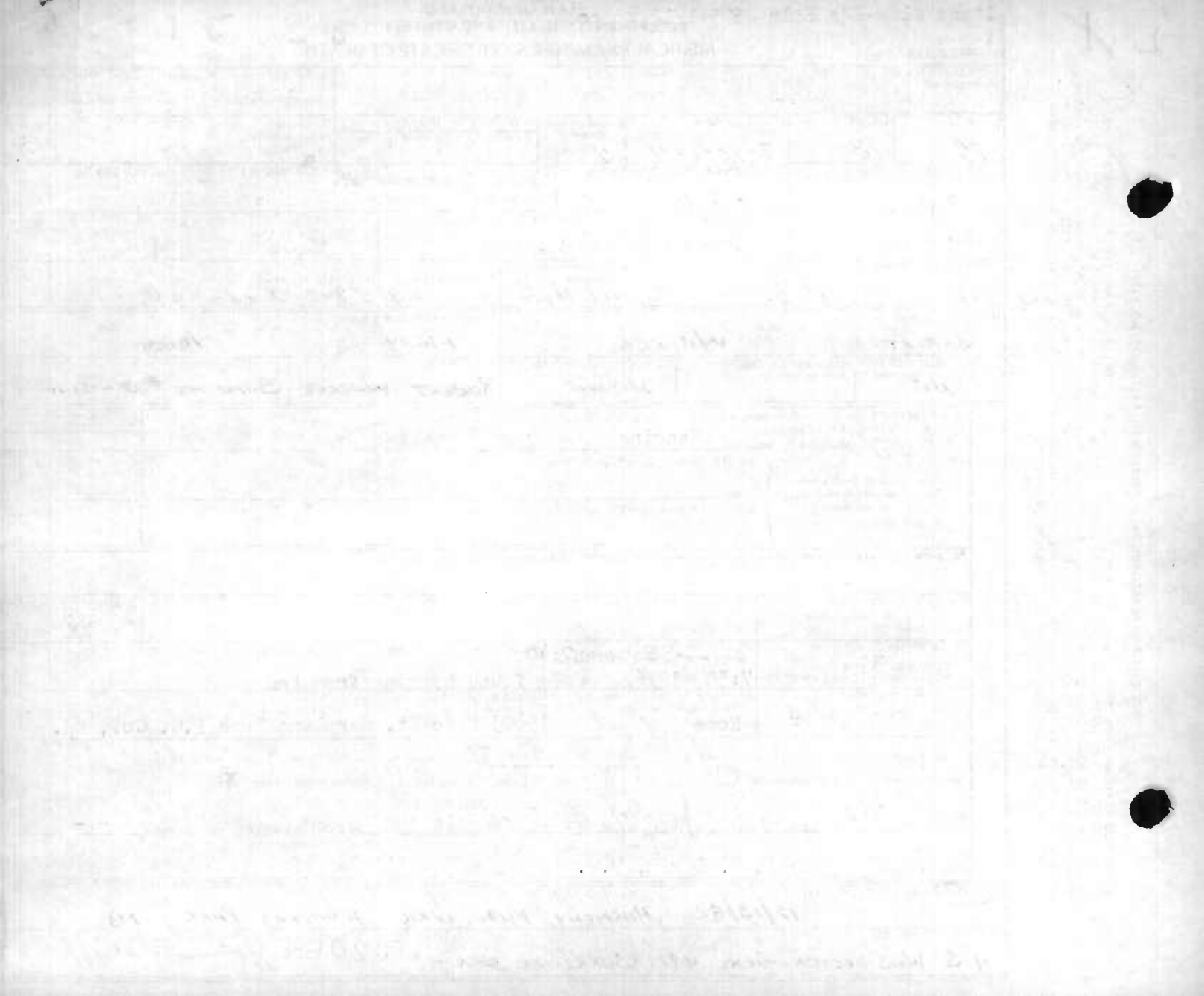
Items #10a-22a Film G575 1/12/82  
**STATE OF MARYLAND**  
**DEPARTMENT OF HEALTH AND MENTAL HYGIENE**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		MONTH		DAY		YEAR		2b. HOUR	
Konard		Walker						12		8		19		82		M	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR	
M	B	7-10-1971		11 YRS.						12		8		19		82	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		WIDOWED		DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH					
D.C.		U.S.A.										Baltimore City,				MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY											
Baltimore		Johns Hopkins Hospital		None													
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS									
MD.		P.G.		Capitol Heights		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		5803-Dade St.									
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME															
ROBERT		WALKER		MARY		YORK											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS											
NO		NONE		ROBERT WALKER - SAME AS #13 ABOVE													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		Hanging		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
9830				DUE TO, OR AS A CONSEQUENCE OF													
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.				(b)		DUE TO, OR AS A CONSEQUENCE OF											
				(c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? HEAD & NECK		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
		7:50 P.M. 12/6/ 19 82		found hanging from bed													
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION													
		Home		5803 Dade St. Maryland Park P.G. Co., Md.													
22a. I certify that I took charge of the remains described above, held on		Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion		death resulted from		Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>											
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED													
Dennis F. Smyth, M.D.		M.D. Assistant		12-9-82													
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS															
Dennis F. Smyth, M.D.		111 Penn Street															
23a. BURIAL, CREMATION, REMOVAL		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION											
		12/13/82		HARMONY MEM. PARK		HIGHLAND PARK, MD.											
24. FUNERAL DIRECTOR		NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE									
H.S. WASHINGTON & SONS		4925 BURLEIGH AVE. N.E.				DEC 20 1982		John J. Carroll									

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 1B shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 2 3 1 9 9 6			
1. FOR STATE REGISTRAR				CERTIFICATE OF DEATH			
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH			
PEARLE P. WALKER				12 18 82 8 <sup>50</sup> PM			
3. SEX Female		4. RACE White <del>XXX</del>		5. DATE OF BIRTH MONTH DAY YEAR 06 30 17		6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N. C.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NONE, GIVE STREET ADDRESS) South Baltimore GM		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Packer for Montgomery Wards		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
13a. STATE Md		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13e. STREET ADDRESS 341 Jeffrey St 21225	
14. FATHER'S NAME Ed		15. MOTHER'S MAIDEN NAME Dora Ann Newson		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			
16b. SOCIAL SECURITY NO. 226129084		17. INFORMANT Junior Goodman					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							
PART 1. DEATH WAS CAUSED BY:							
IMMEDIATE CAUSE (a) Respiratory Insufficiency							
DUE TO, OR AS A CONSEQUENCE OF (b) Metastatic Disease							
DUE TO, OR AS A CONSEQUENCE OF (c) Large Cell Ca Lung							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a							
19a. DATE OF OPERATION 12/15/82		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Obstruction of Cholelith		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 12/03/82 19 to 12/18/82 19, that (I) (we) lost saw the deceased alive on 12/18/82 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE J. Wilson				DEGREE		22c. DATE SIGNED 12/18/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jorge E. Wilson				22e. ADDRESS 32 Baltimore General H			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/22/1982		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, A. A. Co., Md.	
24. FUNERAL DIRECTOR NAME McClary Funeral Homes				25a. DATE REC'D. BY REGISTRAR DEC 21 1982		25b. REGISTRAR'S SIGNATURE R. J. Conner	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

FOR STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE		8 2 3 1 9 9 7	
1. DECEASED NAME (TYPE OR PRINT)		2. DATE OF DEATH		3. REG. NO.	
Theophil WALL		12 26 82		7:10 P.M.	
3. SEX M	4. RACE W	5. DATE OF BIRTH 05 12 24		6. AGE (IN YEARS LAST BIRTHDAY) 58 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Meiser N.D.	7b. CITIZEN OF WHAT COUNTRY? —	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore CITY MD	
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) University of Md. (Hospital)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Physician		12b. KIND OF BUSINESS OR INDUSTRY —
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE Md.		13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS 2807 9th St. 21219	
14. FATHER'S NAME FIRST MIDDLE LAST William Wallace		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Katherine Maderna			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. 501-14-2836	17. INFORMANT Mary Kotowski 2807 9th St.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest 2028 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) congestive Heart Failure DUE TO, OR AS A CONSEQUENCE OF (c) Lymphoma.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Renal Insufficiency					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 12/26 1982, to 12/26 1982, that (I) (we) last saw the deceased alive on 12/26 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Lawrence M. Sigmán		DEGREE MD		22c. DATE SIGNED 12/26/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Lawrence M. SIGMAN		22e. ADDRESS University of Md 225 Green St.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation	23b. DATE 12/29/82	23c. NAME OF CEMETERY OR CREMATORY Fort View Memorial Park		23d. LOCATION CITY OR TOWN COUNTY STATE Lutherville Md.	23e. DATE REC'D. BY REGISTRAR 3/19/83
24. FUNERAL DIRECTOR NAME Charles L. Stevens		25b. REGISTRAR'S SIGNATURE John J. Lamm			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

DHMH-16 50M 1/81  
(VRA 15, 4)

1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 3 1 9 9 8

REG. NO.

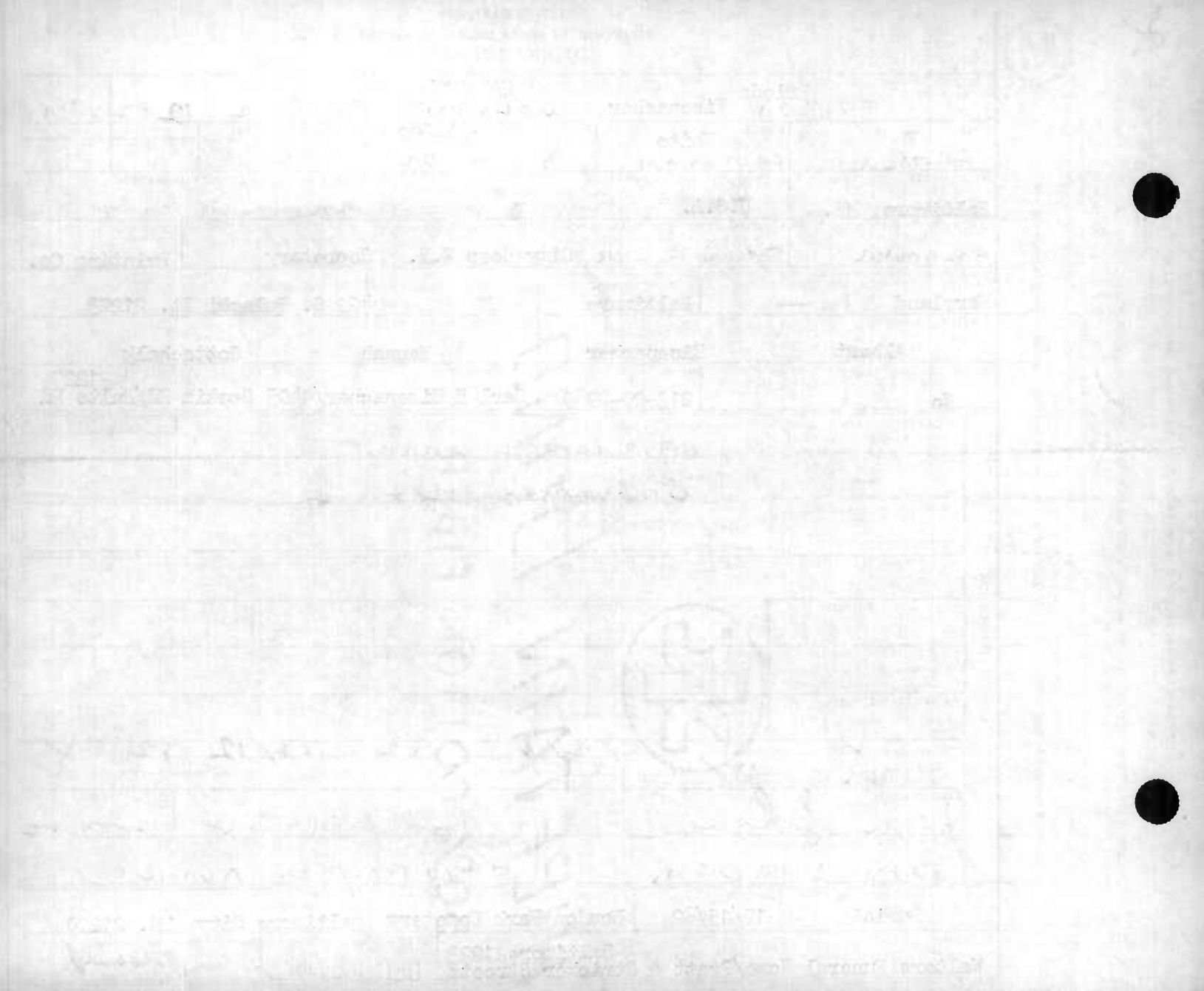
1. DECEASED NAME (TYPE OR PRINT) <b>Frieda Eisenacher</b>		FIRST <b>Frieda</b>		MIDDLE <b>Eisenacher</b>		LAST <b>WALSTON</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>12-12-82 12 12 82</b>		2b. HOUR <b>3 45 A.M.</b>	
3. SEX <b>F</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>3 4 02</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>80</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS <b>80</b>		IF UNDER 24 HRS HOURS MIN. <b>3 45</b>	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Baltimore, Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.					
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>MASON R. LORDCity Hosp N.H.</b>						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Secretary</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Printing Co.</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE <b>Maryland</b>		13b. COUNTY <b>---</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>422 S. Pulaski St. 21223</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Albert Eisenacher</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Hannah Gottschalk</b>				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>			
16b. SOCIAL SECURITY NO. <b>213-09-9989</b>				17. INFORMANT <b>Carl H Eisenacher</b>				ADDRESS <b>4405 Scotia Rd/Balto Md</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>5990 IMMEDIATE CAUSE (a) RESPIRATORY ARREST</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF (b) <b>UROSBPSIS</b>											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (this hospital) attended the deceased from <b>2/16</b> , 19 <b>82</b> , to <b>12/12</b> , 19 <b>82</b> , that (1) <input checked="" type="checkbox"/> last saw the deceased alive on <b>12/10</b> , 19 <b>82</b> , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (1) <input checked="" type="checkbox"/> (2) <input type="checkbox"/> (3) <input type="checkbox"/> (did not) view the body after death.											
22b. SIGNATURE <b>John Shaver</b>						DEGREE		22c. DATE SIGNED <b>12/13/82</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JOHAN SITHA VIZINS</b>						22e. ADDRESS <b>4940 BOSTON AVENUE</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>12/15/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore City, Md. 21229</b>	
24. FUNERAL DIRECTOR NAME <b>Walters Funeral Home/Pratt &amp; Stricker Streets</b>						25a. DATE REC'D. BY REGISTRAR <b>DEC 16 1982</b>					
25b. REGISTRAR'S SIGNATURE <b>Joan J. Connel</b>											

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the funeral director's death certificate.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

Item 22a G576 2/18/83 dad

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 3 1 9 9 9

FOR  
1 - STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) EDITH MAY WALTERS			2a. DATE OF DEATH MONTH DAY YEAR 12-28-82		2b. HOUR 4:35pm
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR June 25, 1904		6. AGE (IN YEARS (LAST BIRTHDAY)) 78 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore, Md.	7b. CITIZEN OF WHAT COUNTRY? U. S. A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.	
10. CITY OR TOWN OF DEATH Baltimore, Md.	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Church Home Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Bookkeeper/Tel. Op.		12b. KIND OF BUSINESS OR INDUSTRY Contractors
13a. STATE Md.			13b. COUNTY ---	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Raymond W. Walters			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Charlotte E. Stichel		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 212-10-44964		17. INFORMANT Baltimore, Md. 21224 Elmer E. Walters-17 N. Curley Street	

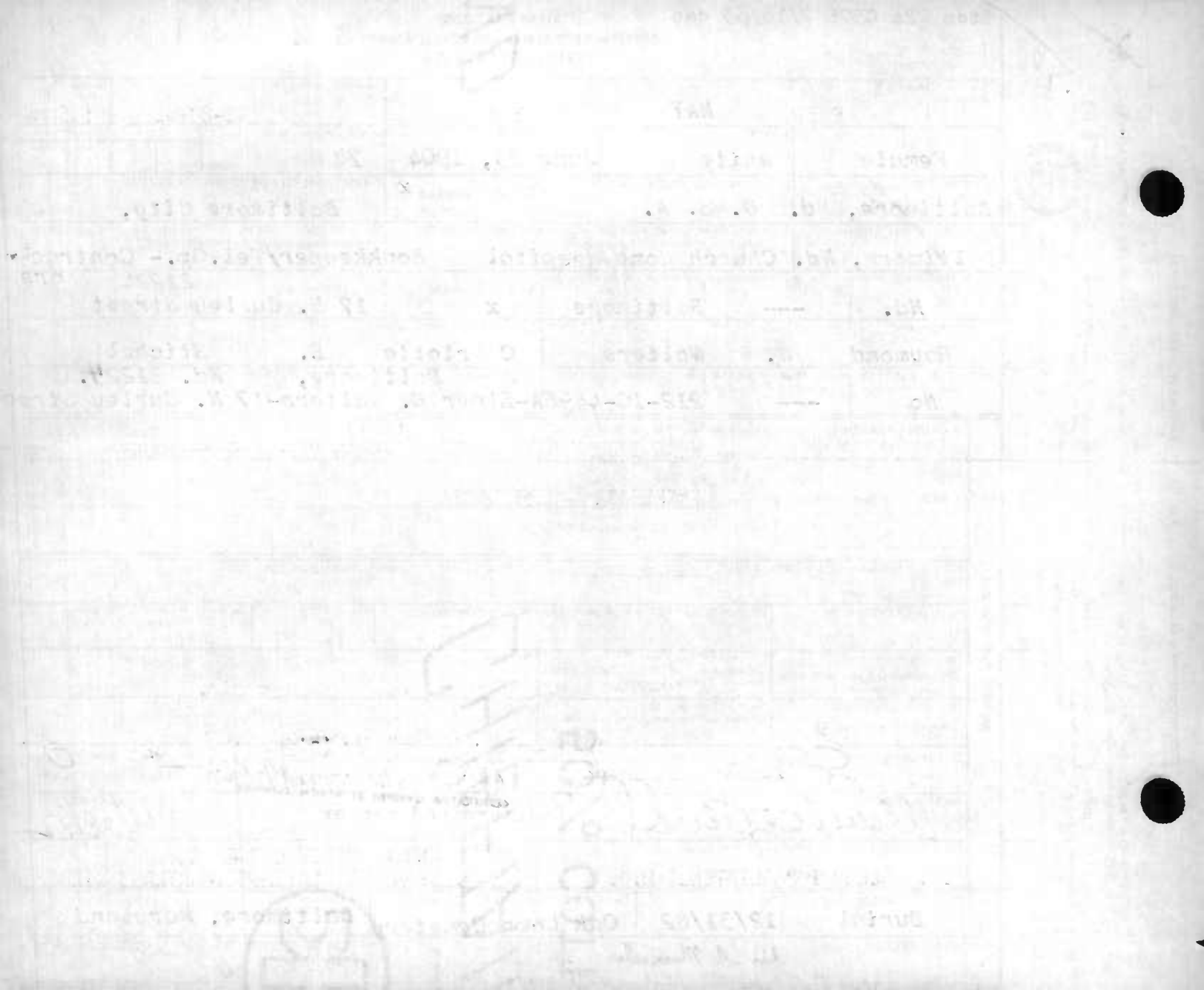
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HEAD INJURY WITH ACUTE CEREBRAL VASCULAR ACCIDENT (LEFT) 4360 DUE TO, OR AS A CONSEQUENCE OF (b) MEMORABLE HEMIPLEGIA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
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PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR ? P.M. 12-28-1982	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) Subject fell from a chair.	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) home	21f. LOCATION STREET CITY OR TOWN COUNTY STATE 17 N. Curley St. Baltimore Md.	
22a. I certify that (1) this hospital attended the deceased from 12-28-82 to 12-28-82, and that in my opinion death occurred on the 28th of December 1982 at 4:35 PM, that (1) we last saw the deceased alive on 12-28-82, and that (2) I did not view the body after death.			
22b. PHYSICIAN'S NAME (TYPE OR PRINT) DR. WALKER IMPAGLIATELLI M.D.		22c. DATE SIGNED 12/28/82	
22d. ADDRESS CHURCH HOSPITAL CORPORATION 100 N. BROADWAY BALTIMORE, MARYLAND 21231		22e. DEGREE OF CERTIFICATION APPROVED BY MEDICAL EXAMINER Undetermined manner PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 12/31/82	23c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery	23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland
24. FUNERAL DIRECTOR NAME John A. Moran		25a. DATE REC'D. BY REGISTRAR DEC 30 1982	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 2 3 2 0 0 0			
1 - STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>ELIZABETH WANCOWICZ</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>DECEMBER 12, 1982</b>			
3. SEX <b>Female</b>				4. RACE <b>Cauc.</b>			
5. DATE OF BIRTH MONTH DAY YEAR <b>11 19 1909</b>				6. AGE (IN YEARS LAST BIRTHDAY) <b>73</b> YRS			
7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.			
10. CITY OR TOWN OF DEATH <b>Baltimore</b>				11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Church Hospital</b>			
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>				12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <b>Md.</b>				13b. COUNTY <b>Baltimore</b>			
13c. CITY OR TOWN <b>Baltimore</b>				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
13e. STREET ADDRESS <b>127 N. Ellwood Ave.</b>							
14. FATHER'S NAME FIRST MIDDLE LAST <b>John Majka</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Karolina Sczyr</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. <b>212-22-0252</b>			
17. INFORMANT ADDRESS <b>Vincent Wancowicz 127 N. Ellwood Ave</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIORESPIRATORY ARREST</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>GASTROINTESTINAL BLEEDING</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>LYMPHOMA STOMACH</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: 18.							
19a. DATE OF OPERATION <b>DECEMBER 11, 1982</b>				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>STOMACH BLEEDING</b>			
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			
21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <b>DECEMBER 11, 1982</b> to <b>DECEMBER 12, 1982</b> , that (I) (we) lost the deceased alive on <b>DECEMBER 12, 1982</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>M. L. Bijpuria</i>				22c. DATE SIGNED <b>12.12.82</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>M. L. BIJPURIA</b>				22e. ADDRESS <b>CHURCH HOSPITAL CORPORATION, 100 N. BROADWAY, BALTIMORE, MARYLAND 21231</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>12/15/82</b>			
23c. NAME OF CEMETERY OR CREMATORY <b>Holy Rosary Cem.</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Md.</b>			
24. FUNERAL DIRECTOR NAME <b>B. Dabrowski &amp; Son 2818 E. Baltimore St.</b>				25a. DATE REC'D. BY REGISTRAR <b>DEC 15 1982</b>			
25b. REGISTRAR'S SIGNATURE <i>B. J. Carver</i>							

1. The first of these is the fact that the Commission has not yet received any information from the Government of the United States regarding the results of its investigation of the activities of the American Friends Service Committee in the Philippines.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned to the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 2 3 2 0 0 1			
1 - FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <i>John W Ward</i>				2a. DATE OF DEATH MONTH DAY YEAR <i>12-25-82</i>		2b. HOUR <i>9 45 PM</i>	
3. SEX <i>M</i>		4. RACE <i>B</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>09-30-00</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>82</i> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Baltimore</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City</i> MD.	
10. CITY OR TOWN OF DEATH <i>Baltimore</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>John L. Beston</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <i>Md.</i>		13b. COUNTY <i>Montg.</i>		13c. CITY OR TOWN <i>Silver Spring</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Samuel Ward</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Marie Hall</i>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. <i>212-14-5828</i>	
17. INFORMANT ADDRESS <i>Medical Records</i>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <i>4409</i> IMMEDIATE CAUSE (a) <i>sepsis</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>pressure ulcers, multiple</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>arteriosclerosis, generalized</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <i>19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>November 4, 1982</i> to <i>Dec 25, 1982</i> that (I) <input checked="" type="checkbox"/> lost saw the deceased alive on <i>Dec 25, 1982</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Julian W. Reed M.D.</i>		DEGREE		22c. DATE SIGNED <i>12/27/82</i>		22d. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <i>JULIAN W. REED M.D.</i>		22f. ADDRESS <i>6115 CHAS. ST. BALTIMORE 21230</i>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>12-31-82</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Ash Mem. Cem.</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Sandy Spring Montg. Md.</i>	
24. FUNERAL DIRECTOR <i>George R. Snouder</i>		24b. ADDRESS <i>247 N. Wash St. Rockville, Md.</i>		25a. DATE REC'D. BY REGISTRAR <i>DEC 30 1982</i>		25b. REGISTRAR'S SIGNATURE <i>James E. Carver</i>	

BP

NO

1. The first step in the process of the design of a new product is the selection of a market. This is done by the marketing department of the company. They will look at the current market and see if there is a need for a new product. If there is, they will then select a market to enter. This is done by looking at the size of the market, the growth rate, and the competition. Once a market has been selected, the next step is to develop a product that meets the needs of that market. This is done by the design department of the company. They will look at the requirements of the market and develop a product that meets those requirements. Once a product has been developed, the next step is to test it. This is done by the testing department of the company. They will use a variety of methods to test the product, including laboratory tests, field tests, and consumer tests. Once the product has been tested, the next step is to produce it. This is done by the manufacturing department of the company. They will use a variety of methods to produce the product, including injection molding, extrusion, and casting. Once the product has been produced, the next step is to distribute it. This is done by the distribution department of the company. They will use a variety of methods to distribute the product, including direct sales, indirect sales, and distribution through intermediaries. Once the product has been distributed, the next step is to promote it. This is done by the promotion department of the company. They will use a variety of methods to promote the product, including advertising, public relations, and sales promotion. Once the product has been promoted, the next step is to evaluate it. This is done by the evaluation department of the company. They will use a variety of methods to evaluate the product, including sales data, customer feedback, and market research. Once the product has been evaluated, the next step is to decide whether to continue to produce it. If the product is successful, the company will continue to produce it. If the product is not successful, the company will stop producing it.

CHIEF

TO O / C

2. The second step in the process of the design of a new product is the selection of a market. This is done by the marketing department of the company. They will look at the current market and see if there is a need for a new product. If there is, they will then select a market to enter. This is done by looking at the size of the market, the growth rate, and the competition. Once a market has been selected, the next step is to develop a product that meets the needs of that market. This is done by the design department of the company. They will look at the requirements of the market and develop a product that meets those requirements. Once a product has been developed, the next step is to test it. This is done by the testing department of the company. They will use a variety of methods to test the product, including laboratory tests, field tests, and consumer tests. Once the product has been tested, the next step is to produce it. This is done by the manufacturing department of the company. They will use a variety of methods to produce the product, including injection molding, extrusion, and casting. Once the product has been produced, the next step is to distribute it. This is done by the distribution department of the company. They will use a variety of methods to distribute the product, including direct sales, indirect sales, and distribution through intermediaries. Once the product has been distributed, the next step is to promote it. This is done by the promotion department of the company. They will use a variety of methods to promote the product, including advertising, public relations, and sales promotion. Once the product has been promoted, the next step is to evaluate it. This is done by the evaluation department of the company. They will use a variety of methods to evaluate the product, including sales data, customer feedback, and market research. Once the product has been evaluated, the next step is to decide whether to continue to produce it. If the product is successful, the company will continue to produce it. If the product is not successful, the company will stop producing it.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 48 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 2 3 2 0 0 2			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Roosevelt S. Ward				2a. DATE OF DEATH MONTH DAY YEAR 12 23 1982		2b. HOUR 11:51 P.M.	
3. SEX MALE		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 8 25 03		6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR IF UNDER 24 HRS 79 YRS. MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore, Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) University Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE Maryland 13c. CITY OR TOWN Baltimore				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 21223 205 N. Amity St. Apt 1	
14. FATHER'S NAME FIRST MIDDLE LAST Samuel Ward		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Spicer		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			
		16b. SOCIAL SECURITY NO. 217-01-2238		17. INFORMANT ADDRESS Edith Ward 205 N. Amity St. Apt 1			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1850 Cardiorespiratory Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Prostatic Cancer DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 11/05 19 82 to 12/23 19 82, that (I) (we) lost saw the deceased alive on 12/23 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE John Howell, M.D.				DEGREE		22c. DATE SIGNED 12/23/82.	
22d. PHYSICIAN'S NAME, (TYPE OR PRINT) John Howell				22e. ADDRESS University of Maryland Hosp.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 12/29/82		23c. NAME OF CEMETERY OR CREMATORY Mount Auburn Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Baltimore Md.	
24. FUNERAL DIRECTOR NAME Wm. C. March F/H Inc. 1101 E. North Avenue ADDRESS				25a. DATE RECEIVED BY REGISTRAR DEC 28 1982		25b. REGISTRAR'S SIGNATURE	

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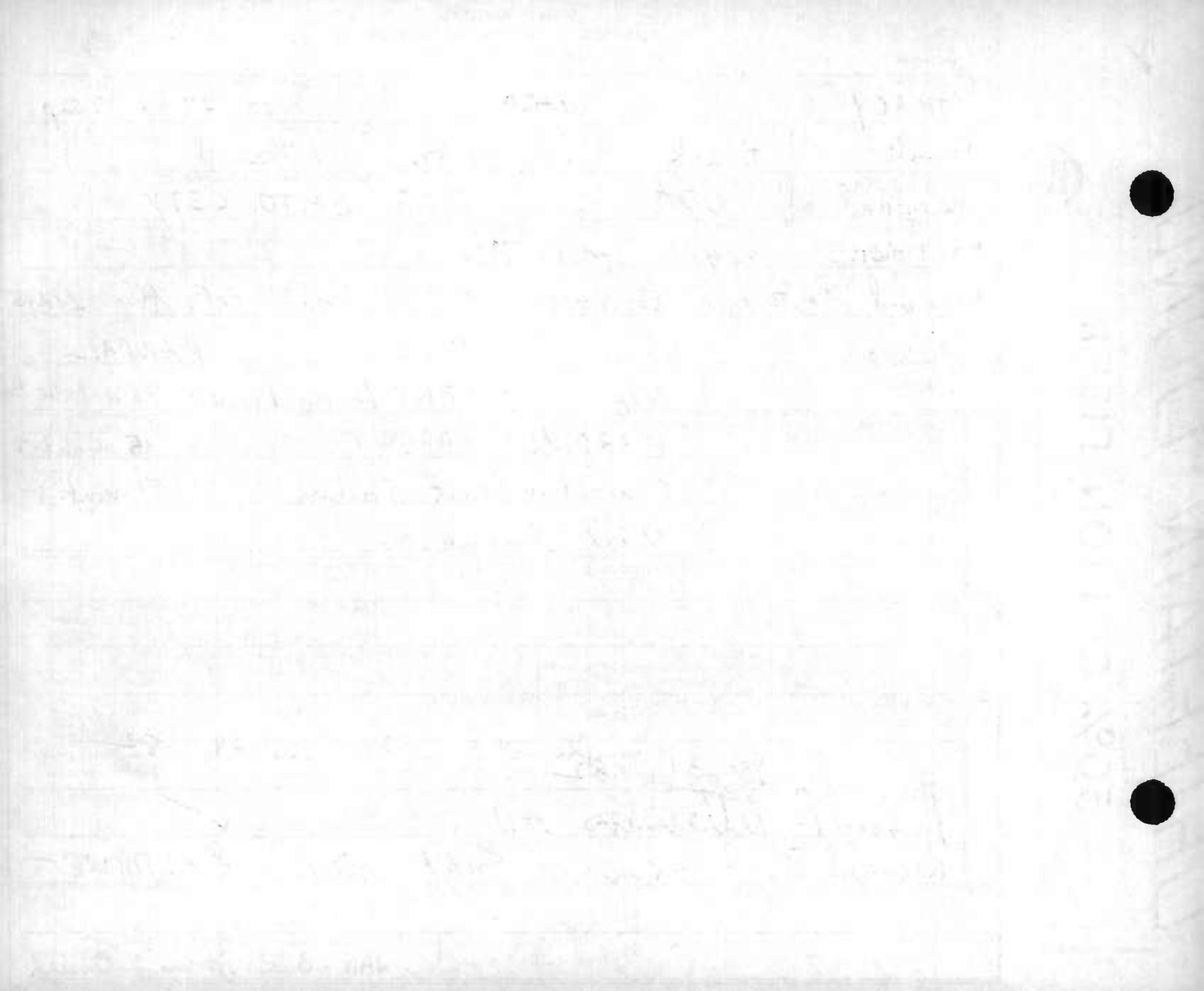
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 10 days after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
1. FOR STATE REGISTRAR					REG. NO. 82 32003				
1. DECEASED NAME					2a. DATE OF DEATH			2b. HOUR	
FIRST MIDDLE LAST					MONTH DAY YEAR			MONTHS DAYS HOURS MIN.	
TRACY WARD					12 27 82			9:02p.m.	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE		7. IF UNDER 1 YEAR	
Female		Black		MONTH DAY YEAR		1 1/2 YRS.		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH		10. IF UNDER 24 HRS.	
Maryland		USA		NEVER MARRIED		BALTO. CITY		HOURS MIN.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION			12a. USUAL OCCUPATION			12b. KIND OF BUSINESS OR INDUSTRY	
BALTIMORE		SINAI HOSPITAL			(TYPE OF WORK FOR MOST OF WORKING LIFE)				
13a. USUAL RESIDENCE					13b. INSIDE CITY LIMITS?		13c. STREET ADDRESS		
Maryland					YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		3828 Belle Ave - 21215		
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME				
Michael Ward					DENISE RANDALL				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?					16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS		
NO					N/A		CHART Denise Randall 3828 Belle Ave		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:									35 minutes
IMMEDIATE CAUSE (a) CARDIAC ARREST									
DUE TO, OR AS A CONSEQUENCE OF (b) Congestive Heart Failure -									7 months -
DUE TO, OR AS A CONSEQUENCE OF (c) Viral Myocarditis									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY		21c. HOW INJURY OCCURRED				
(IF EITHER, NOTIFY MEDICAL EXAMINER)			HOUR A.M. MONTH DAY YEAR		(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
			P.M. 19						
21d. INJURY OCCURRED			21e. PLACE OF INJURY		21f. LOCATION				
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>			(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		STREET CITY OR TOWN COUNTY STATE				
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>									
22a. I certify that (I) (this hospital) attended the deceased from Dec 24, 19 82, to Dec 24, 19 82, that (I) (we) last saw the deceased alive on Dec 24, 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE					DEGREE		22c. DATE SIGNED		
Richard B. Ritterman					MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS				
Richard B. Ritterman					SINAI HOSP. BALTIMORE -				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		
Burial			1/2/83		Zion Hill Cem.		CITY OR TOWN COUNTY STATE		
							Gloucester, Va.		
24. FUNERAL DIRECTOR					25a. DATE REC'D. BY REGISTRAR				
NAME					25b. REGISTRAR'S SIGNATURE				
Wm C March F/H					JAN - 3 1983 John J. Connel				
ADDRESS									
1101 E. North Ave.									



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1 - FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		20. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
CLARICE		L. WARE		December 14, 1982		7:45pm			
3. SEX female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR Sept 27 1918		6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS		IF UNDER 1 YEAR MONTHS DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N. Carolina		7b. CITIZEN OF WHAT COUNTRY? U.S.A		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD			
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL				12a. USUAL OCCUPATION (NATURE OF WORK OR MOST OF WORKING LIFE) Beautician		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md.		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST Clarence Douglass		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Fannie Gore		13e. STREET ADDRESS 2501 Violet Ave.					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213-18-3803		17. INFORMANT Orelia Ware		ADDRESS 2501 Violet Ave.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u> 3453 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Renal Failure - Acute</u> (c) <u>Status Epilepticus</u> DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 wk 1 wk									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 11/1 19 82 to 12/14 19 82, that (I) (we) lost saw the deceased alive on 12/14 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death									
22b. SIGNATURE Arthur M. Feldman MD, PhD				DEGREE MD, PhD				22c. DATE SIGNED 12/14/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Arthur M. Feldman				22e. ADDRESS Johns Hopkins Hospital					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE 12-18-82		23c. NAME OF CEMETERY OR CREMATORY King Mem Pk.		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.			
24. FUNERAL DIRECTOR NAME Carlton C. Douglass		ADDRESS 1012 Penn Ave.		25a. DIED BY NATURAL CAUSE		25b. SIGNATURE John J. Smith			

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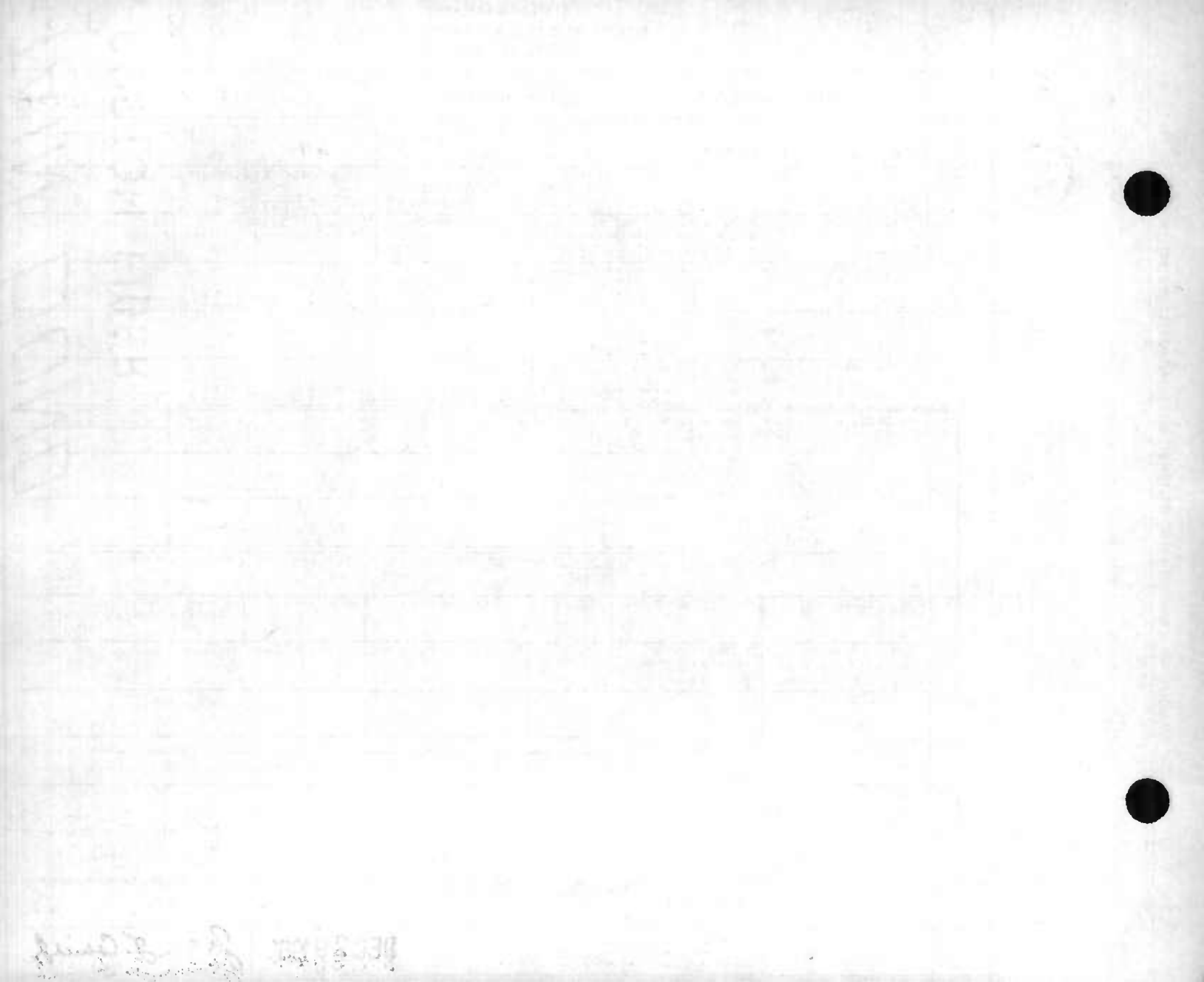
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 is marked, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE					8 2 3 2 0 0 5						
1- FOR STATE REGISTRAR					REG. NO.						
1. DECEASED NAME (TYPE OR PRINT) ARCLANCIA WASHINGTON					2a. DATE OF DEATH MONTH DAY YEAR 12 27 82					2b. HOUR 12:25 P.M.	
3 SEX Female		4 RACE black		5. DATE OF BIRTH MONTH DAY YEAR 11 29 15		6 AGE (IN YEARS LAST BIRTHDAY) 67 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N. Carolina		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.					
10 CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Lutheran Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Maryland		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 3811 Fernhill Avenue 21215			
14 FATHER'S NAME FIRST MIDDLE LAST Lonnie Williams					15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mammie Best						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No				16b. SOCIAL SECURITY NO. 212-14-3670		17 INFORMANT ADDRESS Klondike Ullah 3811 Fernhill Avenue					
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 4360 IMMEDIATE CAUSE (a) Sepsis & shock, UTI DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) CVA, seizure disorder DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) not view the body after death.											
22b. SIGNATURE S. Suwanapool						DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 12/27/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) S. Suwanapool						22e. ADDRESS Lutheran Hospital, MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 12/30/82		23c. NAME OF CEMETERY OR CREMATORY Mount Calvary Cem.				23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Co. Md.			
24. FUNERAL DIRECTOR NAME Wm. C/ March F/H Inc. 1101 E. North Ave.						25a. DATE RECEIVED BY REGISTRAR DEC 29 1982		25b. REGISTRAR'S SIGNATURE John J. Lander			



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE. DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 3 2 0 0 6	
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH			2b. HOUR		
BRENDA			WASHINGTON			XX MONTH DAY YEAR 12-13-82			M		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	IF UNDER 1 YR.	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD			2d. HOUR		
female	Black	7 19 45	37 YRS.	MONTHS	DAYS	12-13-82			8:01A		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			MD.		
Balto. Md.		USA				Baltimore City					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Baltimore		3 S. Payson Street				Unemp.					
13a. STATE											
Md.											
13b. COUNTY											
Balto.											
13c. CITY OR TOWN											
Balto.											
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
13e. STREET ADDRESS											
3 S. Payson Street											
14. FATHER'S NAME											
Alexander											
15. MOTHER'S MAIDEN NAME											
Molly Lawson											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)											
No											
16b. SOCIAL SECURITY NO.											
17. INFORMANT											
Esther Roach 3 S. Payson St.											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I DEATH WAS CAUSED BY:											
5718 IMMEDIATE CAUSE (a) Fatty Liver and fibrosis of liver											
DUE TO, OR AS A CONSEQUENCE OF											
(b)											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):											
19a. DATE OF OPERATION											
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?											
20. AUTOPSY?											
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH											
21b. TIME OF INJURY											
HOUR A.M. MONTH DAY YEAR											
P.M. 19											
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED											
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)											
21f. LOCATION											
STREET CITY OR TOWN COUNTY STATE											
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE											
Margarita A. Korell, M.D.											
TITLE (SPECIFY)											
Assistant MEDICAL EXAMINER											
DATE SIGNED											
12-13-82											
EXAMINER'S NAME (TYPE OR PRINT)											
Margarita A. Korell, M.D.											
ADDRESS											
111 Penn Street											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)											
Burial											
23b. DATE											
12/10/82											
23c. NAME OF CEMETERY OR CREMATORY											
Mt. Zion Cem.											
23d. LOCATION											
Balto., Md.											
COUNTY STATE											
24. FUNERAL DIRECTOR											
NAME											
ADDRESS											
Leroy O. Dyett 4600 Liberty Hgts. Ave.											
25a. DATE RECEIVED BY REGISTRAR											
DEC 17 1982											
25b. REGISTRAR'S SIGNATURE											
John J. Connel											



Female Black 7 10 42 37

Salto, M.

linen.

3 S. Payson Street

Salto.

Md.

Lawson

colly

Roach

Alexander

Yetter Roach 3 S. Payson St.

No

100-100

100-100

100-100

100-100

100-100

100-100



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGES 5 AND 6 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 3 2 0 0 7	
1- FOR STATE REGISTRAR										20. DATE KNOWN OF DEATH	
1. DECEASED NAME FIRST Edward MIDDLE Wasilewski LAST										20. DATE KNOWN OF DEATH MONTH 12 DAY 29 YEAR 1982	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH 3 DAY 27 YEAR 1919		6. AGE (IN YEARS) 63 YRS.		7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		21. DATE PRONOUNCED DEAD MONTH 12 DAY 29 YEAR 1982	
1a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.					
11. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4201 Pennington Avenue				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Cheesecutter for Tasty Cake Co.			12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Maryland		13b. COUNTY ---		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 4201 Pennington Ave., 21226			
4. FATHER'S NAME FIRST Edward MIDDLE LAST Walielewsky				15. MOTHER'S MAIDEN NAME FIRST Cecelia MIDDLE LAST (unknown)				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no			
16b. SOCIAL SECURITY NO. 219-01-5178				17. INFORMANT Theresa Dennis				ADDRESS Md. 21230 321 E. Fort Ave., Balto.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 4292 IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE Dennis F. Smyth M.D.				TITLE (SPECIFY) M.D. Assistant				DATE SIGNED 12/29/82			
EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D.				ADDRESS 111 Penn St. Balto., MD.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/3/1983		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem. Pk.		23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie, A. A. Co., Md.					
24. FUNERAL DIRECTOR NAME McCully Funeral Homes				ADDRESS Balto., Md., 21225 237 E. Patapsco Ave.,				25a. DATE REC'D. BY REGISTRAR JAN 4 1983		25b. REGISTRAR'S SIGNATURE John J. Connelley	

RECEIVED  
JAN 10 1964

TO: [illegible]  
FROM: [illegible]  
SUBJECT: [illegible]  
[illegible text follows]

[illegible text follows]

RECEIVED  
JAN 10 1964  
[illegible text follows]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE					8 2 3 2 0 0 8						
1. FOR STATE REGISTRAR					REG. NO.						
1. DECEASED NAME (TYPE OR PRINT) <b>Dorothy E. Waters</b>					2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR	
							12	31	82	4:45 AM	
3. SEX <b>FEMALE</b>		4. RACE <b>BLACK</b>		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
				MONTH DAY YEAR 05 24 1921		61 YRS.		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>VIRGINIA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE City</b> MD.					
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>UNIVERSITY of MD Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Unemployed</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS		
13a. STATE <b>MD</b>			13b. <b>BALT</b>		13c. <b>BALT</b>		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. <b>755 W. Lexington St #207</b>		
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME						
FIRST MIDDLE LAST <b>Joseph LAWRENCE</b>					FIRST MIDDLE LAST <b>FRANCE Wingfield</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>					16b. SOCIAL SECURITY NO. <b>218-16-5906</b>		17. INFORMANT ADDRESS <b>Michael Wingfield 2838 Boyd St.</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) <b>CARDIO-pulmonary Arrest</b>										4:45 AM 12/31/82	
5939 DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Respiratory insufficiency (possibly)</b>											
DUE TO, OR AS A CONSEQUENCE OF (c) <b>Renal insufficiency (possibly)</b>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Peripheral Vascular Disease</b>											
19a. DATE OF OPERATION <b>0</b>				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>0</b>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>December 15, 1982</b> , to <b>December 31, 1982</b> , that (I) (we) lost saw the deceased alive on <b>December 31, 1982</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Rick L. Shepard, MD</b> DEGREE								22c. DATE SIGNED <b>12/31/82</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>RICK L. Shepard, MD</b>								22e. ADDRESS <b>UNIV MD Hosp. 22 S. Greene St. BALTIMORE MD 21201</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>1/5/83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Calvary</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Brooklyn Md. A.A.</b>			
24. FUNERAL DIRECTOR NAME <b>Chas. A. Rice FSPA 1300 Eutaw Pl.</b>								25a. DATE REC'D. BY REGISTRAR <b>JAN 11 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Carver</b>	



UNITED STATES DEPARTMENT OF THE ARMY

WASHINGTON, D. C. 20315

OFFICE OF THE ADJUTANT GENERAL

WASHINGTON, D. C. 20315

UNITED STATES DEPARTMENT OF THE ARMY

WASHINGTON, D. C. 20315

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>JAMES S WATKINS</b>			2a. DATE OF DEATH MONTH <b>12</b> DAY <b>02</b> YEAR <b>82</b>		2b. HOUR <b>1140 PM</b>		
3. SEX <b>MALE</b>		4. RACE <b>BLACK</b>		5. DATE OF BIRTH MONTH <b>5</b> DAY <b>7</b> YEAR <b>27</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>55</b> YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Winsboro, SC</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE</b> MD.	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>PROVIDENT HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>MD</b>		13b. COUNTY		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST <b>unkn</b> MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST <b>Mary</b> MIDDLE LAST <b>Watkins</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>247-36-3467</b>	
17. INFORMANT <b>Louise Highsmith</b>		ADDRESS <b>2437 Madison Ave.</b>		17a. DATE OF OPERATION		17b. CONDITION FOR WHICH OPERATION WAS PERFORMED	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIORESPIRATORY ARREST</b> <b>5728</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>SHOCK SYNDROME</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>HEPATIC FAILURE</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: **1a**

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>Nov. 17th 1982</b> to <b>Dec 12th 1982</b> , that (I) (we) last saw the deceased alive on <b>Dec 12th 1982</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Ben Magnus-Lawson MD</b>		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>12/12/82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>BEN MAGNUS-LAWSON MD</b>		22e. ADDRESS <b>PROVIDENT HOSP. BALTIMORE</b>					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>12/7/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Eastview Mem. Pk.</b>		23d. LOCATION CITY OR TOWN <b>Balto.</b> COUNTY STATE <b>MD</b>	
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24. FUNERAL DIRECTOR NAME <b>Wm. C. March F/H, Inc.</b> ADDRESS <b>1101 E. North</b>		25a. DATE REC'D. BY REGISTRAR <b>DEC 6-1982</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Connel</b>	
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NO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 48 hours of the death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be retained by the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 3 2 0 1 0

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR		
FIRST	MIDDLE	LAST	MONTH	DAY	YEAR	MONTH		DAY
ETHEL WATSON			12/14/82			5:00 PM		
1. SEX Female			4. RACE Black			5. DATE OF BIRTH		
6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR			IF UNDER 24 HRS		
66 YRS.			MONTHS			DAYS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N. Carolina			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		
12b. KIND OF BUSINESS OR INDUSTRY			13a. STREET ADDRESS 21217 727 Druid Park Lake Dr. Apt. 12J			13b. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME Ras			15. MOTHER'S MAIDEN NAME Nettie Richardson			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		
16b. SOCIAL SECURITY NO. 219-01-2079			17. INFORMANT Hessie Faulcon			ADDRESS 337 E. Littlon Rd.		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u>			
2051 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
(b) <u>sepsis</u>			
(c) <u>chronic myelogenous leukemia</u>		8 years	

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 0

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK NOT AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>12/1</u> , 19 <u>82</u> , to <u>12/14</u> , 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>12/14</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Susan K. Ferrand</u>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 12/14/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Susan K. Ferrand				22e. ADDRESS Johns Hopkins			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 12/20/82		23c. NAME OF CEMETERY OR CREMATORY Piney Grove Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Halifax, N.C.	
24. FUNERAL DIRECTOR NAME ADDRESS Wm. C. March F/H Inc. 1101 E. North Avenue				25a. DATE OF DEC'D. DEC 15 1982		25b. REGISTRAR'S SIGNATURE <u>John J. Carver</u>	

DEPT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D.C. 20535

2

DEC 14 1983

1

DEC 14 1983

North Ave

John G. Smith

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the medical director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office of the health officer with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of cause.

DHMH - 16 50M 1/81  
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 3 2 0 1 1	
1. FOR STATE REGISTRAR		REG. NO.			
1. DECEASED NAME (Type or Print) <b>NAREN WATSON, OLERUD KAREN WATSON</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>DECEMBER 15, 1982</b>		2b. HOUR <b>2:28 A</b>
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>OCT. 25, 1950</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>32</b> YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>NJ</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.	
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (If not in hospital, give street address) <b>THE JOHNS HOPKINS HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Educator</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Education</b>
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE COUNTY <b>MD ANNAPOLIS</b>			13b. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Roy Olerud</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Adeline Gaspari</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>—</b>		17. INFORMANT ADDRESS <b>Kenneth S. Watson - #13</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY <b>4549 IMMEDIATE CAUSE (a) exsanguination</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>bleeding varices</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>end-stage liver disease</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>12/15 2:38 A</b> <b>12/11</b> <b>1982</b>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a <b>hepatorenal syndrome, peritonitis</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>Nov 17</b> , 19 <b>82</b> , to <b>Dec 15</b> , 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>Dec 15</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Scot Remick</b>		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>12/15/82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>SCOT REMICK</b>		22e. ADDRESS <b>600 N. Wolfe St. Baltimore 21205</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Dec 18 1982</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest</b>	
23d. LOCATION CITY OR TOWN <b>Annapolis</b>		23e. DATE RECORDED BY REGISTRAR <b>DEC 20 1982</b>			
24. FUNERAL DIRECTOR NAME <b>Taylor Funeral Chapel - Annapolis, MD</b>		25a. DATE RECORDED BY REGISTRAR <b>DEC 20 1982</b>			

MEDICAL CERTIFICATION

29

Director General  
Director General

Director General  
Director General



EXHIBIT  
No. 1

Mr. J. Edgar Hoover  
Director  
Federal Bureau of Investigation  
Washington, D.C.

Re: [illegible]  
[illegible]

White  
USA  
[illegible]

Received  
[illegible]

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 3 2 0 1 2

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Marion Guy Watson</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>12/13/82</i>		2b. HOUR <i>5 AM</i>	
3. SEX <i>M Male</i>		4. RACE <i>W White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>12 27 50</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>31</i> <del>XXXXXX</del> YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City</i> MD.
10. CITY OR TOWN OF DEATH <i>Baltimore</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Deaton Medical Center</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Drafting Eng.</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Glass Co.</i>
13a. STATE <i>Maryland</i>			13b. COUNTY <i>-----</i>	13c. CITY OR TOWN <i>Baltimore</i>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Marion Guy Watson, Sr.</i>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Annie L. Wilson</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>			16b. SOCIAL SECURITY NO. <i>2500</i>		17. INFORMANT <i>Annie L. Watson</i> ADDRESS <i>Baltimore, Maryland</i> <i>2030 E. Pratt St. 21231</i>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART 1. DEATH WAS CAUSED BY:IMMEDIATE CAUSE (a) *CARDIAC ARREST*APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH*SECONDS*2500  
Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last

DUE TO, OR AS A CONSEQUENCE OF

(b) *ATHEROSCLEROTIC CARDIOVASCULAR DISEASE* *SEVERAL YRS*

DUE TO, OR AS A CONSEQUENCE OF

(c) *DIABETES MELLITUS* *SEVERAL YRS*

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

## MEDICAL CERTIFICATION

19a. DATE OF OPERATION <i>-----</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>-----</i>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from <i>9-1-82</i> , 19 <i>82</i> , to <i>12-13</i> , 19 <i>82</i> , that (1) <input checked="" type="checkbox"/> last saw the deceased alive on <i>12-13</i> , 19 <i>82</i> , and that in my (a) opinion death occurred on the date and hour and from the causes stated above (1) <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Christine L. Comstock</i>				22c. DATE SIGNED <i>12-13-82</i>		22d. ADDRESS <i>5411 OLD FREDERICK RD. BALTIMORE, MD 21223</i>	
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <i>CHRISTINE L. COMSTOCK, MD</i>				22f. ADDRESS <i>5411 OLD FREDERICK RD. BALTIMORE, MD 21223</i>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>Dec. 17, 1982</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill Cem</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Baltimore MD</i>	
24. FUNERAL DIRECTOR NAME <i>Doppel Funeral Homes, Inc.</i> ADDRESS <i>7110 Belair Road Baltimore, Md.</i>				25a. DATE REC'D. BY REGISTRAR <i>DEC 17 1982</i> REGISTRAR'S SIGNATURE <i>John J. Connel</i>			



CHIEFMAN

BO. GOLD



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

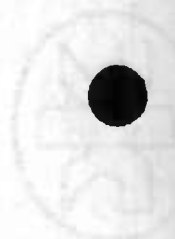
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
1. FOR STATE REGISTRAR					8 2 3 2 0 1 3				
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH				
THOMAS W. WAXTER					12.23.82				
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. HOUR	
Male		Cauc.		6.17.18		64		7:40a.m.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		10. UNDER 24 HRS	
Md.		U.S.				Balto. City		MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Balto.		Holly Hill Manor N. H.				Pastor			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
Md.				Balto.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		3601 Malden Ave.	
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST					
Edward E.				Minnie E.					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS			
Yes				WW 2		Son			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART I. DEATH WAS CAUSED BY:									
1850 IMMEDIATE CAUSE (a) <u>Cd of prostate c metastases</u>									
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
DUE TO, OR AS A CONSEQUENCE OF									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
		P.M. 19							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>4/23/80</u> , 19 <u>80</u> , to <u>12/22/82</u> , 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>12/23</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>F.M. Sugan</u>								22c. DATE SIGNED <u>12/24/82</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)								22e. ADDRESS	
F.M. Sugan M.D.								1501 Biddle St Baltimore 21202	
23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial		12.30.82		Woodlawn		Balto. Md.			
24. FUNERAL DIRECTOR NAME				25a. DATE RECEIVED BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Paul E. Chenoweth 3rd. 3617 Chestnut Ave.				DEC 29 1982		<u>[Signature]</u>			





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 8 2 3 2 0 1 4			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Edna Catherine Webber				2b. HOUR 10:55 AM			
3 SEX Female		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR 11 15 03		6 AGE (IN YEARS LAST BIRTHDAY) 79 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Balto City MD	
10 CITY OR TOWN OF DEATH Balto.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Balto City Hosp.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Homemaker	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE 13c. CITY OR TOWN Md Frederick Knoxville Md				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS PO Box 13/Knoxville Rd. 21758	
14 FATHER'S NAME FIRST MIDDLE LAST George Clarence Merriman				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie Elizabeth Bowers			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. MA-719937		17 INFORMANT ADDRESS P. O. Box 186 William R. Webber - Knoxville, Md. 21758	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Renal + Cardiac Failure							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hr.
7 8939 CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last: DUE TO, OR AS A CONSEQUENCE OF Burn Injury							5 wks.
DUE TO, OR AS A CONSEQUENCE OF							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: history of HTN, CHF							
19a. DATE OF OPERATION 12/2, 12/16/82		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Burns		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 12 P.M. 11 23 1982		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) Apron caught on fire while cooking			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input checked="" type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) home		21f. LOCATION (CITY OR TOWN) STATE Knoxville Md.			
22a. I certify that (I) (this hospital) attended the deceased from 11/23/82 to 12/31/82, that (I) (we) last saw the deceased alive on 12/31/82 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE D. Weinstein MD				DEGREE		22c. DATE SIGNED 12/31/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) D. Weinstein				22e. ADDRESS Balto. Regional Burn Ctr.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/4/83		23c. NAME OF CEMETERY OR CREMATORY Reformed Cemetery		23d. LOCATION (CITY OR TOWN) COUNTY STATE Knoxville, Frederick, Md.	
24 FUNERAL DIRECTOR NAME John T. Williams				24b. ADDRESS John T. Williams Funeral Home Brunswick, Md.		25a. DATE REC'D. BY REGISTRAR 10/10/83	
				25b. REGISTRAR'S SIGNATURE John J. Connel			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Records may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8	2	3	2	0	1	5
1 - FOR STATE REGISTRAR										REG. NO.						
1. DECEASED NAME (TYPE OR PRINT) <i>Thurman G. Webster</i>										2a. DATE OF DEATH MONTH DAY YEAR <i>12 24 82</i>				2b. HOUR <i>10<sup>15</sup> AM</i>		
3. SEX <i>MALE</i>			4. RACE <i>BLACK</i>			5. DATE OF BIRTH MONTH DAY YEAR <i>11 12 19 19</i>			6. AGE (IN YEARS LAST BIRTHDAY) <i>63</i> YRS			7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		8. IF UNDER 24 HRS HOURS MIN.		
9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Virginia</i>			9b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			10. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City,</i> MD.							
10. CITY OR TOWN OF DEATH <i>Baltimore</i>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Baltimore City Hospital</i>							12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)																
13a. STATE <i>Maryland</i>			13b. COUNTY			13c. CITY OR TOWN <i>Baltimore</i>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS <i>1204 Walters Avenue 21239</i>				
14. FATHER'S NAME FIRST MIDDLE LAST <i>Alex Webster</i>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Lena Lewis</i>											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NO</i>					16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>N/A</i>					17. INFORMANT ADDRESS <i>Pearl E. Woolfolk 1204 Walter Avenue</i>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pneumonia</i> <i>4860</i> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>19</i>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK					21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21i. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from <i>12/24/82</i> , 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on <i>12/24</i> , 19 <i>82</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																
22b. SIGNATURE <i>M. Welinsky</i>										DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED <i>12/24/82</i>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>M. Welinsky</i>										22e. ADDRESS						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>					23b. DATE <i>11/29/82</i>			23c. NAME OF CEMETERY OR CREMATORY <i>Eastview Mem. Pk-</i>			23d. LOCATION CITY OR TOWN COUNTY STATE <i>Baltimore Co. Md.</i>					
24. FUNERAL DIRECTOR NAME <i>Wm. C. March F/H Inc. 1101 E. North Avenue</i>										25a. DEC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <i>DEC 28 1982 John J. Conner</i>						



DEC 20 1982  
J. J. J. J.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					8 2 3 2 0 1 6 REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) <b>GEORGE Joseph WEIDINGER</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>12/31/82</b>				2b. HOUR <b>10:52am</b>
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Sept. 23 1907</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>75</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 74 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Baltimore</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.			
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Church Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Maintenance Mech</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Crown Cork &amp; Seal</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b> 13b. COUNTY <b>---</b> 13c. CITY OR TOWN <b>Baltimore</b> 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					13e. STREET ADDRESS <b>2014 Portugal St. 21231</b>				
14. FATHER'S NAME FIRST MIDDLE LAST <b>George Weidinger, Sr.</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Margaret Fitchbach</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>			16b. SOCIAL SECURITY NO. <b>216-01-3378</b>		17. INFORMANT ADDRESS <b>Elizabeth Weidinger 2014 Portugal St. 21231</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIO RESPIRATORY ARREST</b> <b>4100</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>PROBABLY FOLLOW ACUTE MYOCARDIAL INFARCTION - PNEUMONIA - PLEURAL EFFUSION</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>SION</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>---</b>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>Nov. 16</b> 19 <b>82</b> to <b>Dec. 31</b> 19 <b>82</b> , that (I) <input checked="" type="radio"/> lost the deceased alive on <b>Dec. 31</b> 19 <b>82</b> , and that in (my) <input checked="" type="radio"/> opinion death occurred on the date and hour and from the causes stated above. (I) <input type="radio"/> (we) <input type="radio"/> (did) <input type="radio"/> (did not) view the body after death.									
22b. SIGNATURE <i>Walker Impagliatelli</i>			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>12/31/82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>WALKER IMPAGLIATELLI M.D.</b>			22e. ADDRESS <b>CHURCH HOSPITAL CORPORATION 100 N. BROADWAY BALTO. MD. 21231</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>Jan. 4 1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Sacred Heart of Jesus</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Maryland</b>		
24. FUNERAL DIRECTOR NAME ADDRESS <b>Lilly &amp; Zeiler, Inc. 1901 Eastern Ave.</b>					25a. DATE REC'D. BY REGISTRAR <b>JAN 3 1983</b>		25b. REGISTRAR'S SIGNATURE <i>John J. Smith</i>		





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

DHMH-16 50M 1/BI  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 3 2 0 1 7

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST LOUISA E WEINBERGER			2a. DATE OF DEATH MONTH DAY YEAR 12 2 82		2b. HOUR 9:16 AM	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 10 17 82		
6. AGE (IN YEARS LAST BIRTHDAY) 100 YRS.		7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.		8. CITIZEN OF WHAT COUNTRY? USA		
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.		10. CITY OR TOWN OF DEATH BALTO.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HAMILTON NURSING CENTER		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) H.S.N.F.		12b. KIND OF BUSINESS OR INDUSTRY		13a. STREET ADDRESS 3907 ARBON AVE 21214		
14. FATHER'S NAME FIRST MIDDLE LAST Christian Schmuck		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Miller		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) NO		
16b. SOCIAL SECURITY NO. 217-45-1577		17. INFORMANT Mrs Evelyn A Hertel		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ischemic heart disease 4149 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (the hospital) attended the deceased from 11-16 19 82 to 12-2 19 82 that (I) (we) lost saw the deceased alive on 11-22 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.						
22b. SIGNATURE Marion C. Kowalewski MD		22c. DATE SIGNED 12/2/82		22d. PHYSICIAN'S NAME (TYPE OR PRINT) M.C. Kowalewski		
22e. ADDRESS 8604 HARBOR RD		23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/4/82		
23c. NAME OF CEMETERY OR CREMATORY Moreland Mem Park		23d. LOCATION Baltimore, Maryland		24. FUNERAL DIRECTOR NAME Leonard J Ruck Inc		
24. ADDRESS Baltimore, Maryland		25a. DATE REC'D BY REGISTRAR DEC 6 - 1982		25b. REGISTRAR'S SIGNATURE John J. Caserio		

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U.S. DEPARTMENT OF AGRICULTURE  
WASHINGTON, D.C.

DEC 6 1902  
J. H. H. H.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 3 2 0 1 8

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) STEPHEN PETER WENDLING		2a. DATE OF DEATH MONTH DAY YEAR 12 22 82		2b. HOUR 5:12 PM	
2. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 06 08 31	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST. AGNES HOSPITAL		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) BOTTLE MACHINE		12b. KIND OF BUSINESS OR INDUSTRY GLASS CO.		13a. STREET ADDRESS 3043 STAFFORD STREET, 21223	
13a. STATE MARYLAND		13b. COUNTY ---		13c. CITY OR TOWN BALTIMORE	
14. FATHER'S NAME FIRST MIDDLE LAST STEPHEN WENDLING		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY E. TUCKER		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) [IF YES, GIVE WAR OR DATES] NO	
16b. SOCIAL SECURITY NO. 215-28-7591		17. INFORMANT IRENE A. WENDLING		ADDRESS 3043 STAFFORD ST., 21223	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Terminal emphysema (COPD)</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>12/21</u> , 19 <u>82</u> , to <u>12/22</u> , 19 <u>82</u> , that (I) (we) lost saw the deceased alive on <u>12/21</u> , 19 <u>82</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. <u>12/22/82 5:12 PM</u>					
22b. SIGNATURE <u>Sting</u>		22c. DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22d. DATE SIGNED 12/22/82	
22e. PHYSICIAN'S NAME (TYPE OR PRINT) M. SINGH		22f. ADDRESS ST. AGNES HOSPITAL, 900 S. CATON AVENUE			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 12-27-82		23c. NAME OF CEMETERY OR CREMATORY LOUDON PARK	
23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE CITY MARYLAND		24. FUNERAL DIRECTOR NAME ADDRESS HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVE. 21229			
25a. DATE REC'D BY REGISTRAR DEC 27 1982		25b. REGISTRAR'S SIGNATURE <u>John J. Lewis</u>			

MEDICAL CERTIFICATION

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



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MAY 19 1964



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral home, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified before burial or cremation.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8	2	3	2	0	1	9
CERTIFICATE OF DEATH										REG. NO.						
1. DECEASED NAME (TYPE OR PRINT) <b>Morris J. Werntz</b>										2a. DATE OF DEATH MONTH DAY YEAR <b>December 12, 1982</b>				2b. HOUR <b>10 A M</b>		
3. SEX <b>male</b>		4. RACE <b>white</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>July 15 1913</b>				6. AGE (IN YEARS LAST BIRTHDAY) <b>69</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 74 HRS HOURS MIN.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City MD.</b>								
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>3302 Clarks Lane Apt C (21215)</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Employee</b>				12b. KIND OF BUSINESS OR INDUSTRY <b>Government</b>						
13a. STATE <b>Maryland</b>		13b. COUNTY		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>3302 Clarks Lane Apt C (21215)</b>								
14. FATHER'S NAME FIRST MIDDLE LAST <b>Harry N. Werntz</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mollie B. Bolnick</b>					16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>						
16b. SOCIAL SECURITY NO. <b>215-22-8737</b>					17. INFORMANT ADDRESS <b>Mr. Morris A. Baker 1 Slade Ave Apt 704 (21208)</b>											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b> <b>4100</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <b>Hypertensive Cardiovascular Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Year.</b>																
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____																
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from <b>12-6-82</b> to <b>12-12-82</b> that (I) (we) lost saw the deceased alive on above, (I) (we) (and) (did not) view the body after death.																
22b. SIGNATURE <b>[Signature]</b> DEGREE										ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>12/13/82</b>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Dr. Barbara A Cochran</b>										22e. ADDRESS <b>6506 Park Heights Ave</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>				23b. DATE <b>DEC. 14, 1982</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Beth T. Filoh Cem</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE Maryland</b>						
24. FUNERAL DIRECTOR'S NAME <b>Sol Levinson &amp; Bros Inc. (21215)</b>										25a. DATE REC'D. BY REGISTRAR <b>DEC 15 1982</b>						
25b. REGISTRAR'S SIGNATURE <b>John J. Conner</b>																

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a post-mortem examination must be performed.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 3 2 0 2 0  
REG. NO.

1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		FIRST Alice	MIDDLE M.	LAST West	2a. DATE OF DEATH MONTH December 16, 1982	DAY 16	YEAR 1982	2b. HOUR 5:54 P M
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH 2 DAY 4 YEAR 01		6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.				
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Maryland General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Md.		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1701 N. Eutaw St. 21217		
14. FATHER'S NAME FIRST William		MIDDLE B.		LAST Tyler		15. MOTHER'S MAIDEN NAME FIRST Alice		MIDDLE Monroe		LAST
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A		17. INFORMANT Alice Cooper		ADDRESS 5231 Denmore Ave.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio-pulmonary arrest</u> 5789 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Internal hemorrhage</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) <u>Septic Shock</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 hours 6 hours
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>Peripheral Vascular disease, Atherosclerosis</u>										
19a. DATE OF OPERATION 12/14/82		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Lower gastrointestinal hemorrhage				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from December 10, 1982, to December 16, 1982, that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on December 16, 1982, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) did <input checked="" type="checkbox"/> (not) view the body after death.										
22b. SIGNATURE <i>John A. Lampe</i>		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 12/16/82		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John Lampe, M. D.		22e. ADDRESS c/o Maryland General Hospital								
23a. BURIAL, CREMATION, REMOVAL (SPECIAL) Burial		23b. DATE 12/20/82		23c. NAME OF CEMETERY OR CREMATORY St. Thomas Cem.		23d. LOCATION CITY OR TOWN Randallstown, Md.		COUNTY STATE		
24. FUNERAL DIRECTOR NAME Wm C March F/H		ADDRESS 1101 E. North Ave		25a. DATE REC'D. BY REGISTRAR DEC 20 1982		25b. REGISTRAR'S SIGNATURE <i>John J. Gair</i>				

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FEB 10 1985  
U.S. DEPARTMENT OF AGRICULTURE  
WASHINGTON, D.C. 20250

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TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1 DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
ROSS, E. WEST		DEC. 19, 1982		M	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YEAR	
FEMALE	WHITE	Nov. 22, 1896	86	IF UNDER 24 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
MARYLAND	U.S.A.		BALTIMORE CITY MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
BALTIMORE	3117 CHESLEY AVE.		NOXELL CORP.		on line
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. INSIDE CITY LIMITS?	13c. STREET ADDRESS		
MO.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	3117 CHESLEY AVE.		
14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME	16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			
GEORGE S. O'BRIEN	ELLEN REXROTH	NO			
16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS			
215-18-3915	FAMILY RECORDS				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) Coronary artery disease					4 years
4149					
DUE TO, OR AS A CONSEQUENCE OF					
(b)					
DUE TO, OR AS A CONSEQUENCE OF					
(c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
		HOUR A.M. MONTH DAY YEAR			
		P.M. 19			
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION	
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		(AT HOME STREET FACTORY OFFICE FARM, ETC.)		CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from April, 1971, to Dec. 19, 1982, that (I) (we) last saw the deceased alive on Nov. 3, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
Donald R. Jandorf		M.D.		12-21-82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
DONALD R. JANDORF		7403 HARFORD ROAD, PARKVILLE			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION	23e. STATE	
BURIAL	12-22-1982	BALTIMORE NATIONAL	BALTIMORE	MARYLAND	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
NAME ADDRESS		DEC 30 1982		John J. Connel	
EVANS FUNERAL CHAPEL 8800 HARFORD RD.					

DEC 10 1981

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office of the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

FOR  
1 - STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 3 2 0 2 2

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>DONALD M. WEYGAND</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>12 17 82</b>		2b. HOUR <b>7:15 PM</b>					
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Feb. 26, 1920</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>62</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Mass.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.				
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>THE UNION MEMORIAL HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Assist. Manager</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Retail Sales</b>		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>			13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>21234</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>2733 Superior Avenue 21234</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>George Weygand</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Elizabeth</b>			16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>				
16b. SOCIAL SECURITY NO. <b>018-18-7765</b>			17. INFORMANT ADDRESS <b>Ruth G. Weygand 2733 Superior Ave. 21234</b>							
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>INTER CRANIAL HEMORRAGE</b> <b>4310</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>OLD HEMORRAGE 12/15/82</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>HYPERTENSION.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>NO</b>										
19a. DATE OF OPERATION <b>NONE</b>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>NONE</b>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) <b>21a. INJURY OCCURRED</b> WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) <b>NONE</b>					
21d. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21e. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (a) (this hospital) attended the deceased from <b>DEC 15th 1982</b> to <b>DEC 17th 1982</b> , that (a) (we) lost the deceased alive on <b>DEC 17th 1982</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not see the body after death, so state.)										
22b. SIGNATURE <b>David Leichtling</b>			DEGREE <b>M.D.</b>			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED <b>12/17/82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DAVID LEICHTLING M.D.</b>			22e. ADDRESS <b>201 E. UNIVERSITY PARKWAY</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>Dec. 20, '82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Moreland Mem. Park</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Co., MD</b>		
24. FUNERAL DIRECTOR NAME <b>William E. Johnson</b>			ADDRESS <b>8521 Loch Raven Blvd.</b>			25a. DATE REC'D. BY REGISTRAR <b>DEC 20 1982</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Calver</b>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a report filed.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 3 2 0 2 3

FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>JAMES P. WHALEN</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>12 17 82</b>			2b. HOUR <b>10:45 P.</b>			
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Oct. 16, 1941</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>41</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.			
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT NURSING FACILITY, GIVE STREET ADDRESS) <b>UNION MEMORIAL HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Gas Station Attendant</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>3903 Eierman Ave.</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>James T. Whalen</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Pauline Renoff</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>1960-1964</b>		17. INFORMANT <b>Pauline Whalen</b>		ADDRESS <b>3903 Eierman Ave.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Diabetic Ketoacidosis</b> <b>2501</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>12/17</b> , 19 <b>82</b> , to <b>12/17</b> , 19 <b>82</b> , that (I) (we) lost saw the deceased alive on <b>12/17</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Brian H. Kahn, M.D.</b>				DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>12/17/82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>BRIAN H. KAHN, M.D.</b>				22e. ADDRESS <b>UNION MEMORIAL HOSPITAL</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Dec. 22, 1982</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gardens of Faith</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Maryland</b>			
24. FUNERAL DIRECTOR NAME <b>Leonard J. Ruck, Inc. Baltimore, Maryland</b>				ADDRESS		25a. DATE REC'D. BY REGISTRAR <b>DEC 20 1982</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Connel</b>	

MEDICAL CERTIFICATION

NOTICE





FOR  
1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 3 2 0 2 4

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>John H. Wheatley</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>12 / 21 / 82</b>			2b. HOUR <b>10:15AM</b>	
3. SEX <b>MALE</b>		4. RACE <b>BLACK</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>10 06 98</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>84</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore city MD.</b>	
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>University Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>LABORER</b>	
						12b. KIND OF BUSINESS OR INDUSTRY <b>RET.</b>	

13a. STATE <b>MD.</b>			13b. COUNTY <b>DOR.</b>		13c. CITY OR TOWN <b>SMITHVILLE</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>P.O. Box 91 Taylors Is. MD.</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>John T. WHEATLEY</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>MARGARET TRAVERS</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. <b>217-07-5713A</b>			17. INFORMANT <b>JUANITA W. TAYLORS E. MD.</b>			ADDRESS		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>1629</b> IMMEDIATE CAUSE (a) <b>Out Cell Carcinoma</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF (b) <b>GI Bleed</b>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		DUE TO, OR AS A CONSEQUENCE OF (c) <b>Hepatic Dysfunction</b>	

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a <b>Renal Insufficiency</b>			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE			

22a. I certify that (I) (this hospital) attended the deceased from <b>Dec 18</b> , 19 <b>82</b> , to <b>Dec 21</b> , 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>Dec 21</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <b>Lawrence M. Sigman</b>		22c. DATE SIGNED <b>12-21-82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Lawrence M. Sigman</b>		22e. ADDRESS <b>University of Md Cancer Center</b>	

23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT) <b>BURIAL</b>		23b. DATE <b>12-26-82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>JEFFERSON</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>SMITHVILLE DOR. MD.</b>	
24. FUNERAL DIRECTOR NAME <b>Frederick C. Davis</b>		25a. DATE REC'D. BY REGISTRAR <b>DEC 28 1982</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Canine</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 42 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

10



FILE

100%

100%

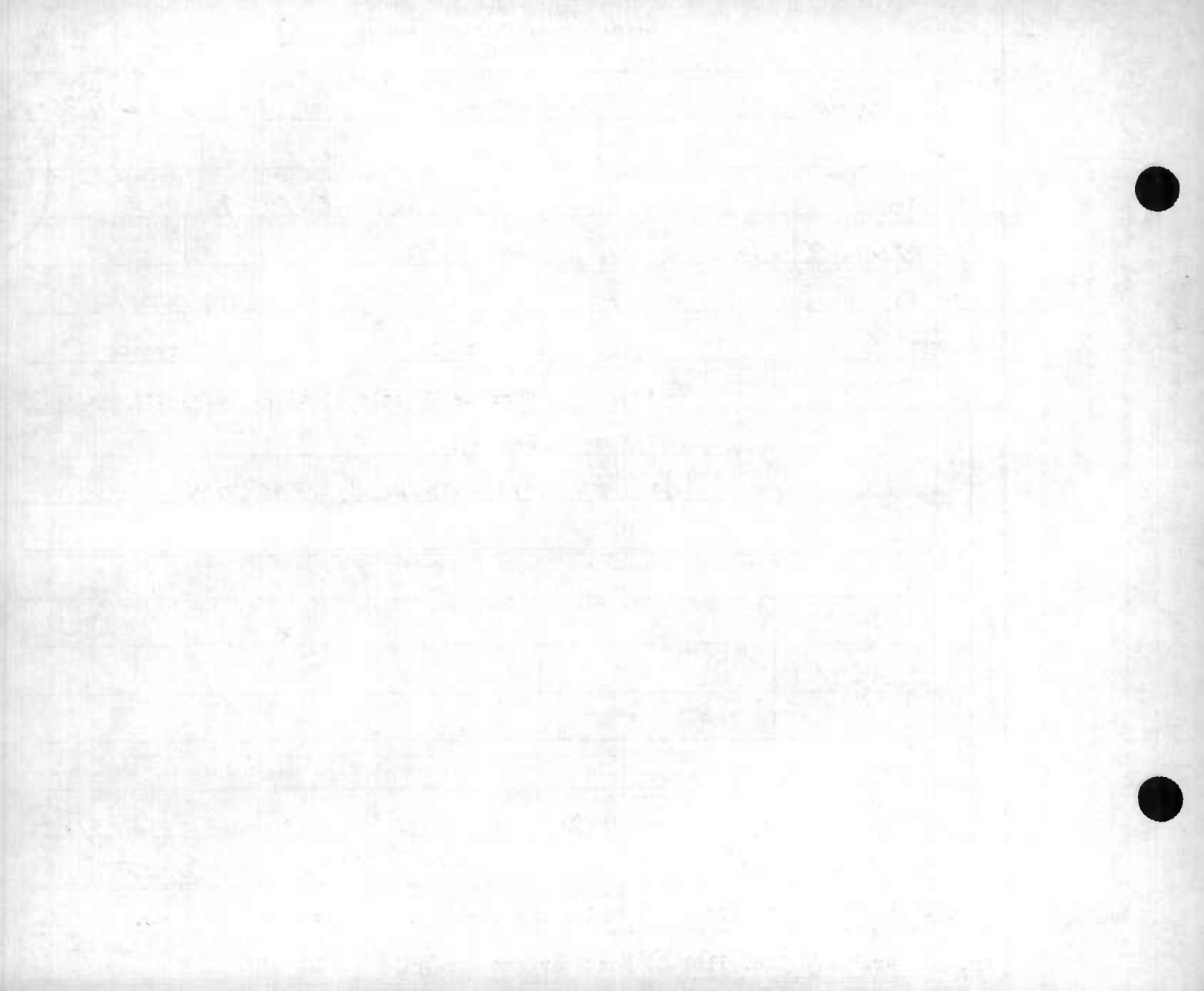
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified about it.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 3 2 0 2 5 REG. NO.						
1. FOR STATE REGISTRAR					2. DECEASED NAME (TYPE OR PRINT) <b>MARCHO WHEATLEY</b>							3a. DATE OF DEATH MONTH DAY YEAR <b>12 13 82</b>			7b. HOUR <b>11:35AM</b>	
3 SEX <b>F</b>		4. RACE <b>B</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>5 23 35</b>			6 AGE (IN YEARS LAST BIRTHDAY) <b>47</b> YRS			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH <b>CITY</b> MD.								
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SINAI HOSPITAL</b>					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY						
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE <b>MD</b>		13b. COUNTY <b>BALT</b>		13c. CITY OR TOWN <b>BALT</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>3105 WOODLAND AVE</b>								
14. FATHER'S NAME FIRST MIDDLE LAST <b>SAMUEL Bryant</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Ethel Bryant</b>											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>UNK</b>		17 INFORMANT ADDRESS <b>Charles Wheatley 1241 E. Lafayette Avenue</b>												
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b> <b>4100</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>ACUTE MYOCARDIAL INFARCTION</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>CONTRIBUTING TO DEATH</b>																
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)												
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE												
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																
22b. SIGNATURE <b>Harvey Rosen</b>					DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>12/13/82</b>						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Harvey ROSEN</b>					22e. ADDRESS <b>SINAI HOSP OF BALT</b>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>12/17/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>King Memorial Pk.</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Co. Md.</b>									
24. FUNERAL DIRECTOR NAME <b>Wm. C. March F/H Inc. 1101 E. North Avenue</b>					25a. DATE REC'D. BY REGISTRAR <b>DEC 17 1982</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Conner</b>									



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 7 days of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8 2 3 2 0 2 6	
1. FOR STATE REGISTRAR										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>Agnes Wheaton</b>						2a. DATE OF DEATH MONTH DAY YEAR <b>12/8/82</b>		2b. HOUR <b>9:30 AM</b>			
3. SEX <b>Female</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>10 1 22</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>60</b>		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN) <b>Balto., MD.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore</b> MD.					
10. CITY OR TOWN OF DEATH <b>Balto.</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION <b>Mercy Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <b>Md.</b>						13b. COUNTY		13c. CITY OR TOWN <b>Balto.</b>			
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						13e. STREET ADDRESS <b>509 Laurens St.</b>					
14. FATHER'S NAME FIRST MIDDLE LAST						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Bertha</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. <b>215 32 1703</b>		17. INFORMANT ADDRESS <b>Stephanie Brown 2034 Druid Hill Ave.</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>1990</b> IMMEDIATE CAUSE (a) <b>Cardio respiratory failure</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>advanced Carcinomatosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b></b>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>11/29</b> , 19 <b>82</b> , to <b>12/8</b> , 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>12/8</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Gerald J. Scallion</b>						DEGREE <b>Attending Physician</b>		22c. DATE SIGNED <b>12/8/82</b>		22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>GERALD J. SCALLION</b>	
22e. ADDRESS <b>Mary Hays Balto. Md.</b>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>12/13/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Auburn Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Balto., Md.</b>			
24. FUNERAL DIRECTOR <b>Leroy O. Dyett 4600 Liberty Hgts. Ave.</b>						25a. DATE REC'D. BY REGISTRAR <b>DEC 10 1982</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Conner</b>			



Female	Black	17	1	22	60
Balto., Md.	USA				Baltimore
Balto.	Merov Hospital				
Mt.	Balto.	x			509 Laurens St.
					Berlin

215 35 1503  
Stephanie Brown 2034 Broad Hill Ave.

CHIEF

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Merov O. Sweet 4800 Liberty Hols. Ave.  
Bertal  
MAY 1963  
Mt. Auburn Cem.  
Baltimore, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked at item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 3 2 0 2 7			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST Clifford Wheeler		2a. DATE OF DEATH MONTH DAY YEAR 12 1 82		2b. HOUR M	
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 7 26 20		6. AGE (IN YEARS LAST BIRTHDAY) 62	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash. D.C.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 222 E. Lafayette Ave.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md.		13b. COUNTY		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes 1943-1947			
16b. SOCIAL SECURITY NO. 579-18-9758		17. INFORMANT Regina Mason		ADDRESS 222 E. Lafayette Ave.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c): PART I. DEATH WAS CAUSED BY: 4100 IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hr or so			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):							
19a. DATE OF OPERATION N/A		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED N/A		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that (I) (this hospital) attended the deceased from Sept 9, 19 80, to Sept 9, 19 82, that (I) (we) lost saw the deceased alive on Sept 9, 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.	
22b. SIGNATURE Herbert A. Kushner M.D.		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/2/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) HERBERT A. KUSHNER, M.D.		22e. ADDRESS 800 Braddish Avenue, Balto., Md. 2126					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/7/82		23c. NAME OF CEMETERY OR CREMATORY Md. Veteran's Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Crownsville, Md.	
24. FUNERAL DIRECTOR NAME Chatman-Harris				ADDRESS 1701 McCulloh Street		25a. DATE REC'D. BY REGISTRAR DEC 6 - 1982	
				25b. REGISTRAR'S SIGNATURE John J. Conner			





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 2 3 2 0 2 8  
CERTIFICATE OF DEATH

1. FOR STATE REGISTRAR		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH	
FIRST MIDDLE LAST Albert H. WHITE		MONTH DAY YEAR HOUR 12 27 82 1:05 A.M.	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)
M	B	MONTH DAY YEAR 08 06 42	40 YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH
MARYLAND	U.S.A.		Baltimore city MD.
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
BALTIMORE	UNIVERSITY HOSPITAL	Laborer/CLERK	WAREHOUSE
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
MARYLAND		BALTIMORE	
14. FATHER'S NAME (FIRST MIDDLE LAST)	15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST)	13e. STREET ADDRESS	
GEORGE A. WHITE	DOROTHY M. CHEW	2900 WINDSOR AVE. #21216	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS	
NO	219-38-1625	2900 Windsor Ave. Anthony VanDyke-Baltimore, Md. 21216	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY:			
IMMEDIATE CAUSE (a) <u>Respiratory arrest</u>			
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Esophageal Carcinoma</u>			
DUE TO, OR AS A CONSEQUENCE OF (c) _____			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)			
19a. DATE OF OPERATION			
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK	21e. PLACE OF INJURY [AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.]	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>12/26</u> , 19 <u>82</u> , to <u>12/27</u> , 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>12/26</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE		DEGREE	22c. DATE SIGNED
Lawrence M. Sigman		MD	12/27/82
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS	
Lawrence M. Sigman		University of Md. Hospital 22 S Green St	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE
Burial	12/30/82	Mt. Calvary	Baltimore MD
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
HERBERT E. NUTTER		3035 W. North Ave	JAN 3 1983

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the funeral director after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filled within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner may be notified at once.

## MEDICAL CERTIFICATION

Items 9 Thru 13 1-13-83										STATE OF MARYLAND																			
1. FOR STATE REGISTRAR										DEPARTMENT OF HEALTH AND MENTAL HYGIENE																			
CERTIFICATE OF DEATH										REG. NO. 8 2 3 2 0 2 9																			
1. DECEASED NAME (TYPE OR PRINT)					FIRST MIDDLE LAST					2a. DATE OF DEATH					MONTH DAY YEAR					2b. HOUR									
BABY BOY					WHITE					12-24-82					17 03					M									
3. SEX					4. RACE					5. DATE OF BIRTH					6. AGE (IN YEARS LAST BIRTHDAY)					IF UNDER 1 YEAR					IF UNDER 24 HRS				
MALE					BLACK					MONTH DAY YEAR 12 23 82					YRS. MONTHS DAYS					HOURS MIN.									
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)					7b. CITIZEN OF WHAT COUNTRY?					8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					9. BALTIMORE CITY OR COUNTY OF DEATH														
MARYLAND					U.S.A.										13 BALTIMORE CITY MD.														
10. CITY OR TOWN OF DEATH					11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)					12b. KIND OF BUSINESS OR INDUSTRY									
Baltimore Md					University Hospital																								
13a. STATE										13b. COUNTY					13c. CITY OR TOWN					13d. STREET ADDRESS									
MD															BALTIMORE					34 11 ADAMSON AVE 21229									
14. FATHER'S NAME										15. MOTHER'S MAIDEN NAME																			
FIRST MIDDLE LAST										FIRST MIDDLE LAST																			
ROBERT LOUIS LEE										PAMELA ANNETTE WHITE																			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)										16b. SOCIAL SECURITY NO.					17. INFORMANT ADDRESS														
															MOTHER.														
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH														
PART 1. DEATH WAS CAUSED BY:																													
IMMEDIATE CAUSE (a) 7468 CARDIAC ARREST																													
DUE TO, OR AS A CONSEQUENCE OF (b) HEART BLOCK - COMPLEX CONGENITAL HEART DISEASE																													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.																													
DUE TO, OR AS A CONSEQUENCE OF (c) RESPIRATORY ARREST																													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																													
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?					20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?														
										YES <input type="checkbox"/> NO <input type="checkbox"/>					YES <input type="checkbox"/> NO <input type="checkbox"/>														
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					21b. TIME OF INJURY					21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)																			
					HOUR A.M. MONTH DAY YEAR P.M. 19																								
21d. INJURY OCCURRED					21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)					21f. LOCATION																			
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK										CITY OR TOWN COUNTY STATE																			
22a. I certify that (I) (this hospital) attended the deceased from DEC. 23, 1982, to DEC. 24, 1982, that (I) (we) lost saw the deceased alive on DEC. 24, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																													
22b. SIGNATURE										DEGREE					22c. DATE SIGNED														
Mary Lenore Keszler MD.															12-24-82														
22d. PHYSICIAN'S NAME (TYPE OR PRINT)										22e. ADDRESS																			
MARY LENORE KESZLER, MD										22 S. GREENE ST. BALTIMORE, MD.																			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)					23b. DATE					23c. NAME OF CEMETERY OR CREMATORY					23d. LOCATION														
Removal					12/30/82										CITY OR TOWN COUNTY STATE														
24. FUNERAL DIRECTOR NAME										ADDRESS					25a. DATE REC'D. BY REGISTRAR					25b. REGISTRAR'S SIGNATURE									
Anatomy Board										Balto., Md.					JAN 12 1983														



POPULATION  
CHIEFLY



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 7 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

Item 21b-22a Film 576										STATE OF MARYLAND											
FOR STATE REGISTRAR 2-10-83 en										DEPARTMENT OF HEALTH AND MENTAL HYGIENE											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH																					
1. DECEASED NAME (TYPE OR PRINT)										2a. DATE KNOWN OF DEATH											
CHARLES N. WHITE, Jr.										<input checked="" type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR 12 26 1982											
3 SEX		4 RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		7d. HOUR							
Male		White		5 16 62		20 YRS.						12 26 1982		12:45 P M							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH									
Maryland				USA								Baltimore City 21201 MD.									
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY					
Baltimore				University Hospital 21201								Tree Expert				Dawn Tree Ex.					
13a. STATE				13b. COUNTY				13c. CITY OR TOWN				13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS							
Maryland								Baltimore				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		3046 Keswick Road 21211							
14. FATHER'S NAME (FIRST MIDDLE LAST)										15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST)											
Charles N. White, Sr.										Josephine Friend											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)										16b. SOCIAL SECURITY NO.					17. INFORMANT ADDRESS						
No										220-82-6392					Frank Dudek 9594 Muirkirk Rd. Laurel, Md. 20708						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cranio-cerebral trauma</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____																					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).																					
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?											
										HEAD ONLY YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH										20b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR											
										P.M. 12 17 1982											
21a. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK										21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)											
										F211a											
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)										21d. LOCATION (STREET CITY OR TOWN COUNTY STATE)											
Subject fell down steps										1501 Woodheights ave Baltimore Md											
22a. I certify that I took charge of the remains described above, held on death resulted from:										Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion											
Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/>										Undeclared cause of death <input checked="" type="checkbox"/>											
ACTUAL SIGNATURE										TITLE (SPECIFY)											
Ann M. Dixon, M.D.										M.D. Assistant MEDICAL EXAMINER											
EXAMINER'S NAME (TYPE OR PRINT)										DATE SIGNED 12-27-82											
ADDRESS										111 Penn St., Balto., Md. 21201											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)										23b. DATE		23c. NAME OF CEMETERY OR CREMATORY						23d. LOCATION (CITY OR TOWN COUNTY STATE)			
Burial										12/30/82		Meadowridge Memorial Pk.						Baltimore Md.			
24. FUNERAL DIRECTOR NAME										25a. DATE REC'D. BY REGISTRAR										25b. REGISTRAR'S SIGNATURE	
A. Alan Seitz, Jr.										3818 Roland Ave. 21211										JAN 3 1983	

A. Alan Peltz, Jr. 3018 Roland Ave. 31211

Burial 12/30/42 Westridge Memorial Pk. Baltimore Md.

No 220-42-1392

Charles W. White, Sr.

Maryland Baltimore

x

3016 Reswick Road

31211

31201

Tree Export

Dawn Tree

31201

Male White

5 10 02 30

Jr.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
1. FOR STATE REGISTRAR					8 2 3 2 0 3 1 REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST IRIS P. WHITE					2a. DATE OF DEATH MONTH DAY YEAR December 27, 1982			2b. HOUR 9 a.m.	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR June 8, 1910		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2209 Belair Rd. (Residence)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Home Maker		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 2209 Belair Road 21213	
14. FATHER'S NAME FIRST MIDDLE LAST Samuel O. Roberts		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alice C. Horner							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 213-16-8304B		17. INFORMANT ADDRESS Gorman T. White Sr. 2209 Belair Rd. 21213					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). <u>Carcinoma of the Stomach</u> 1519 DUE TO, OR AS A CONSEQUENCE OF (b). Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c). APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 28 months									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) (this hospital) attended the deceased from <u>August 12-13</u> , 19 <u>80</u> , to <u>Dec 27</u> , 19 <u>82</u> , that (1) (we) last saw the deceased alive on <u>12-13</u> , 19 <u>82</u> , and that in (2) (our) opinion death occurred on the date and hour and from the causes stated above; (2) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>George E. Lowe</u>				DEGREE <u>MD</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12-28-82			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. George E. Lowe M.D.				22e. ADDRESS 3703 Belair Road Baltimore, Maryland					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Dec 30 1982		23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland			
24. FUNERAL DIRECTOR NAME Leonard J. Ruck, Inc. Baltimore, Maryland				25a. DATE REGD. BY REGISTRAR DEC 28 1982		25b. REGISTRAR'S SIGNATURE <u>John J. Carroll</u>			

DISIVIS

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Doc 30 1285

[A 100]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use in the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified.

DPHM: 16-30M (1/81)  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 3 2 0 3 2

FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST Mary White		2a. DATE OF DEATH MONTH DAY YEAR 12 4 82		2b. HOUR 10:40 PM	
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 4 27 97		6. AGE (IN YEARS LAST BIRTHDAY) 85	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Lutheran Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Unemployed		12b. KIND OF BUSINESS OR INDUSTRY at home	
13a. STATE Md		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Holland Baucknight		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Kuma 21215		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 217-05-8974	
16c. ADDRESS 3304 Pennsylvania Ave		17. INFORMANT Alice Frazier		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary CE - 1991 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I (this hospital) attended the deceased from 12-4-82, 19, to 12-4-82, 19, that I (we) last saw the deceased alive on 12-4-82, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Sissay Awoke		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 12-4-82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Sissay Awoke		22e. ADDRESS Lutheran Hospital					
23a. BURIAL, CREMATION, REMOVAL (BY) Burial		23b. DATE 12/10/82		23c. NAME OF CEMETERY OR CREMATORY MORRISAN		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore MD	
24. FUNERAL DIRECTOR NAME M. P. Harris		24b. ADDRESS 6387 Gilman St		25a. DATE REC'D. BY REGISTRAR DEC 6 - 1982		25b. REGISTRAR'S SIGNATURE John J. Conner	

MEDICAL CERTIFICATION

Handwritten text, mostly illegible due to fading and bleed-through. Some words like "The" and "and" are visible.

Handwritten text, mostly illegible due to fading and bleed-through. Some words like "The" and "and" are visible.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH																			
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH		DAY		YEAR		2b. HOUR		MIN.	
BABY GIRL						WHITLEY		12		26		1982				12:25		00:01	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS									
FEMALE		WHITE		12 26 82		6. AGE (IN YEARS LAST BIRTHDAY)		MONTHS		DAYS		HOURS		MIN.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH													
MARYLAND		U.S.A.				BALTIMORE CITY													
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY													
BALTIMORE		ST. AGNES HOSPITAL		NONE															
13a. STATE		13b. CITY OR TOWN		13c. INSIDE CITY LIMITS?		13d. STREET ADDRESS													
MARYLAND		BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		140 EDGEWOOD AVENUE												21228	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME																	
FIRST		MIDDLE		LAST		FIRST		MIDDLE		LAST									
ROBERT WHITLEY		DIANA		Unknown															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT		ADDRESS													
				DIANA WHITLEY SAME AS # 13															
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) - <i>Cardio-Respiratory Failure</i> 7690 DUE TO, OR AS A CONSEQUENCE OF (b) - <i>Hyaline Membrane Disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) - <i>Shunt Prematurity</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.																			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?													
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>													
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE															
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																			
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED													
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS																	
ARTHUR L. MACARAEG		ST Agnes Hosp.																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE													
BURIAL		1/18/83		NEW CATHEDRAL CEMETERY		BALTIMORE													
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE															
WITZKW P.A.		JAN 19 1983		John J. Connel															
1630 EDMONDSON AVENUE, CATONSVILLE, MD. 21228																			



100



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 3 2 0 3 4

REG. NO.

FOR  
1 - STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) (James) Louis Whorl			2a. DATE OF DEATH MONTH DAY YEAR 12 26 82			2b. HOUR M M	
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 9 14 17		6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1400 E. Madison Ave. Apt. 516				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
13a. STATE Maryland		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST N/A		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST N/A		13e. STREET ADDRESS 1400 E. Madison Ave. Apt. 516			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 224-07-6300		17. INFORMANT ADDRESS Ruth Whorl 1400 E. Madison Ave. Apt. 516			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART 1. DEATH WAS CAUSED BY:

1991

IMMEDIATE CAUSE (a)

METASTATIC UNDIFFERENTIATED CARCINOMA

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH  
~2 months

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Death occurred at home so I do not know details.

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 11/2, 1982, to 12/21, 1982, that (I) (we) last saw the deceased alive on 12/21, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Alison Freifeld		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 12/29/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ALISON FREIFELD		22e. ADDRESS 601 N. Broadway, Baltimore, Md.					

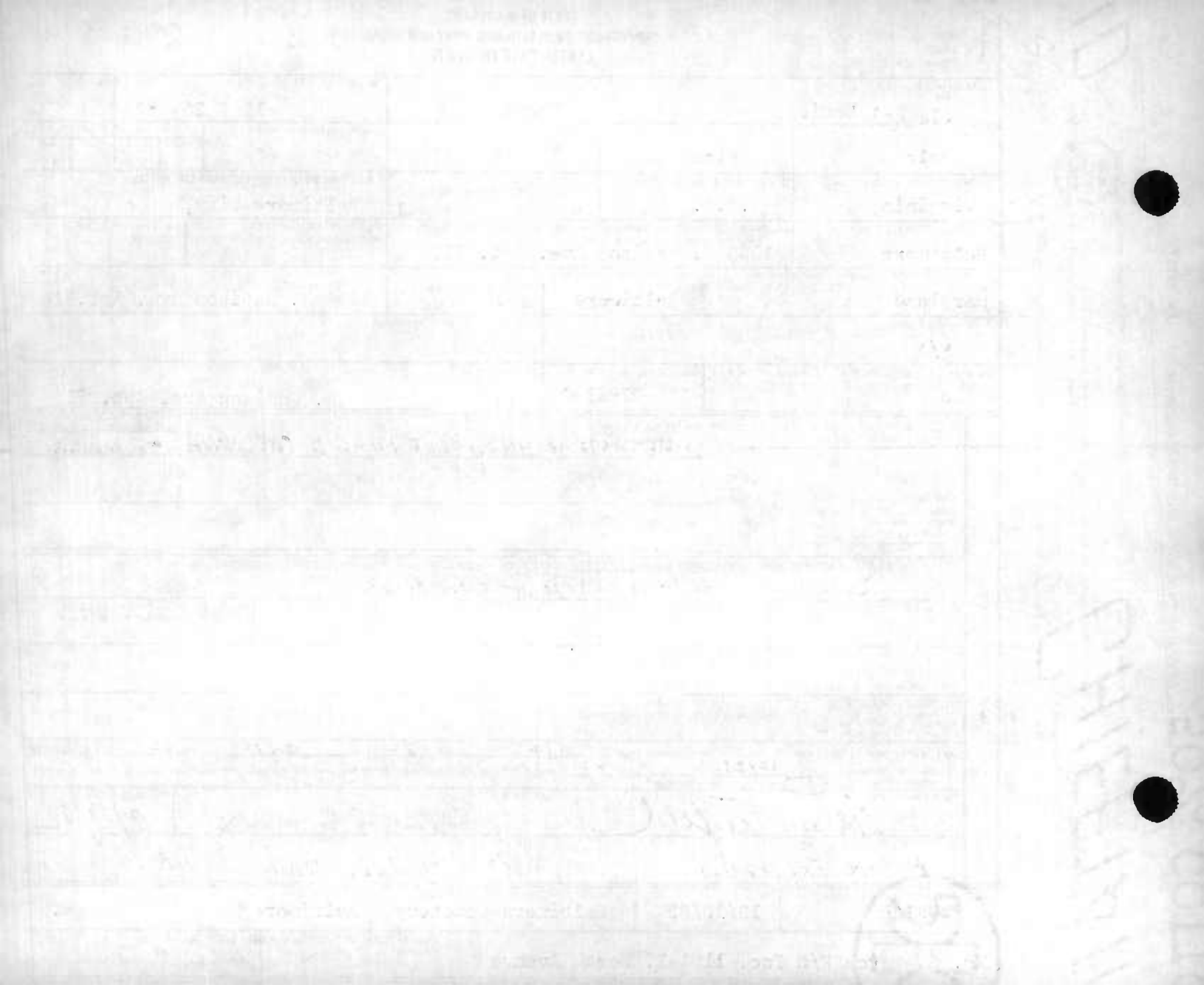
23a. BURIAL, CREMATION, REMOVAL (TYPE) BURIAL		23b. DATE 12/30/82		23c. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.	
24. FUNERAL DIRECTOR NAME Wm. C. March F/H Inc. 1101 E. North Avenue				25a. DATE REC'D. BY REGISTRAR DEC 30 1982		25b. REGISTRAR'S SIGNATURE John J. Carroll	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Burial may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called at once.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrars, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>JOSEPH F. WICKLESS</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>12-27-82</b>		2b. HOUR <b>10:30<sup>AM</sup></b>
1. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>9 12 13</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>69</b> YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE, CITY</b> MD.		
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>ST AGNES HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Safety Director</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Baltimore City</b>
13a. STATE RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>		13b. COUNTY <b>A.A.</b>	13c. CITY OR TOWN <b>Linthicum</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS <b>543 Forrest View Road 21090</b>
14. FATHER'S NAME FIRST MIDDLE LAST <b>Joseph A. Wickless</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Elizabeth H. Sadler</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>WW II 214-20-1484</b>		17. INFORMANT ADDRESS <b>Dolores M. Wickless 543 Forrest View Rd. 21090</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: <b>1850</b> IMMEDIATE CAUSE (a) <b>Cardiac and respiratory arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Bilateral pneumonia</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Prostatic CA &amp; bone metastases of severe anemia</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR (A.M. OR P.M.) MONTH DAY YEAR <b>10:30 P.M. 12/27/1982</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>12/27/1982</b> to <b>12/27/1982</b> , that (I) (we) last saw the deceased alive on <b>12/27/1982</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>TH. QUANG N.</b>		DEGREE		22c. DATE SIGNED <b>12/27/82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>TH. QUANG N.</b>		22e. ADDRESS <b>St. Agnes Hospital</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>12/31/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Brooklyn Pk. A.A. Maryland</b>		24. FUNERAL DIRECTOR NAME ADDRESS <b>Hubbard Funeral Home, Inc. 4107 Wilkens Ave. 21229</b>			
25a. DATE REC'D. BY REGISTRAR <b>DEC 29 1982</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Conner</b>			

BP

COLLECTOR LINES

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpaper. Pages 1 and 2 should be filed with the health officer, death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified to examine the body.

## MEDICAL CERTIFICATION

Item #6 Film G574 FOR 1 - STATE 22-22-82 gw REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		8 2 3 2 0 3 6 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <del>FRANK</del> <b>FRANK A. WIEDERMANN</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>12 -18-82</b>		2b. HOUR <b>4:20 AM</b>
3. SEX <b>MALE</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>11 14 15</b>		6. AGE (IN YEARS (LAST BIRTHDAY)) <b>67</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.	
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>BALTIMORE CITY HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>TRUCKER</b>	
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>Baltimore</b>		13c. STREET ADDRESS <b>7201 FAIT AVE</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>William Wiedermann</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Frieda Klemstein</b>		ADDRESS <b>7201 Fait Avenue</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>		16b. SOCIAL SECURITY NO. <b>217-03-0585</b>		17. INFORMANT <b>Dorothy Wiedermann Balto., MD. 21224</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>4100 IMMEDIATE CAUSE (a) MASSIVE HEART ATTACK</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>END STAGE CORONARY ARTERY DISEASE</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>WITH TRIPLE VESSEL DISEASE : 90% LEFT MAIN</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a. <b>None</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR (A.M.) MONTH DAY YEAR <b>4:20 P.M. December 18 1982</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>DEC. 14</b> , 19 <b>82</b> , to <b>DEC 18</b> , 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>DEC 18</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Martin Schusselberg</b>		DEGREE <b>N.O.</b>		22c. DATE SIGNED <b>12/18/82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>MARTIN SCHUSSELBERG</b>		22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>12/21/1982</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Moreland Mem. Park</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Maryland</b>					
24. FUNERAL DIRECTOR NAME ADDRESS <b>Duda-Ruck, Inc. 7922 Wise Avenue Dundalk, MD. 21222</b>		25a. DATE OF DEATH <b>DEC 21 1982</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Connel</b>	

STATE OF TEXAS  
COUNTY OF DALLAS

Know all men by these presents, that

JOHN A. SMITH, of the County of Dallas, State of Texas,

do hereby certify that

the within and foregoing is a true and correct copy of the

original thereof, as the same appears from the records of the

County of Dallas, State of Texas, this 1st day of

January, 1901.

JOHN A. SMITH, County Clerk.

My commission expires this 1st day of

January, 1902.

Witness my hand and the seal of the County of Dallas, State of Texas, this 1st day of

January, 1901.

JOHN A. SMITH, County Clerk.

My commission expires this 1st day of

January, 1902.

JOHN A. SMITH, County Clerk.

My commission expires this 1st day of

January, 1902.

John A. Smith

338183

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 1/81  
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO. 8 2 3 2 0 3 7				
1. DECEASED NAME (TYPE OR PRINT) <b>MICHAEL F. WIEGMANN</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>12-24-82</b>			2b. HOUR <b>9:11 P</b> M	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>November 25, 1905</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>77</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>United States</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore city</b> MD.			
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Bon Secour Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired-Disabled</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Carpet Co.</b>	
13a. STATE <b>Maryland</b> 13b. COUNTY <b>Baltimore</b> 13c. CITY OR TOWN <b>- -</b>					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>1314 Evering Ave. (21237)</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>John - Wiegmann</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Barbara - Guttenberger</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>					16b. SOCIAL SECURITY NO. <b>213-07-3275</b>		17. INFORMANT ADDRESS <b>Marie Petersen 1314 Evering Ave.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: <b>2900 IMMEDIATE CAUSE (a) Cardiac arrest</b>									
DUE TO, OR AS A CONSEQUENCE OF <b>ASCVD</b>									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: <b>senile dementia</b>									
DUE TO, OR AS A CONSEQUENCE OF									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>12/10/82</b> P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <b>1/28</b> , 19 <b>82</b> , to <b>12/24</b> , 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>12/10</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.									
22b. SIGNATURE <b>Kuang-Yen Huang M.D.</b>			DEGREE <b>M.D.</b>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>12/25/82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>KUANG-YEN HUANG</b>			22e. ADDRESS <b>Bon Secours Hosp</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>Dec. 28, 1982</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Sacred Heart of Jesus</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>- - Baltimore Co., Md.</b>		
24. FUNERAL DIRECTOR NAME <b>Lilly &amp; Zeiler Inc.</b> ADDRESS <b>700 S. Conkling St.</b>					25a. DATE REC'D. BY REGISTRAR <b>DEC 28 1982</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Conner</b>		

MEDICAL CERTIFICATION

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Initial  
Dec. 2, 1962  
J. Edgar Hoover  
U.S. Department of Justice  
Washington, D.C.  
100-388688  
DEC 3 1962  
J. Edgar Hoover  
U.S. Department of Justice  
Washington, D.C.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrars, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Item 16Bg575 1/12/83GAB

# STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

8 2 3 2 0 3 8

FOR  
1. STATE REGISTRAR Item #16 G575 1-21-83 g

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Calvert Wiley</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>12 8 82</b>		2b. HOUR M <b>AM</b>
3. SEX <b>Female</b>	4. RACE <b>Black</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>7 12 13</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>69</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Balto.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City,</b> MD.	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>405 Mount Holly Street,</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>			13b. COUNTY <b>Baltimore</b>	13c. CITY OR TOWN <b>Baltimore</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Greenwood Waters</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Lillie Plater</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>		16b. SOCIAL SECURITY NO. <b>112-32-4777</b>		17. INFORMANT ADDRESS <b>Louise Jones 624 Wallerson Rd.</b>	
18. CAUSE OF DEATH (Enter only one cause per item 18-1-77) PART I. DEATH WAS CAUSED BY: <b>1590</b> IMMEDIATE CAUSE (a) <b>CARDIO RESPIRATORY ARREST</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>SHOCK</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>CARCINOMA OF THE BOWEL</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH HOURS MONTHS
PART 2. OTHER CAUSAL CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a. <b>DIABETES MELLITUS, &amp; CONGESTIVE FAILURE</b>					
19a. DATE OF OPERATION <b>UNKNOWN</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>BOWEL CANCER</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>OCTOBER</b> 19 <b>82</b> , to <b>DECEMBER 8</b> , 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>DECEMBER 1</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>James Richardson MD</b>		DEGREE		22c. DATE SIGNED <b>12/8/82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JAMES RICHARDSON MD</b>		22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>12/13/82</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Arbutus Mem. Pk.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Arbutus, Md.</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>Wm. C. March F/H Inc. 1101 E. North Avenue</b>			25a. DATE REC'D. BY REGISTRAR <b>DEC 9 1982</b>	25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	



777-50-11

DIFFERENTIAL

20% COLLOID



STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 3 2 0 3 9			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>MARY WILKERSON</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>12-17-82</b>			2b. HOUR <b>8:29A<sub>M</sub></b>
3. SEX <b>Female</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>12 1894</b>		6. AGE (WHEN LAST BIRTHDAY) <b>86</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Roxboro, N.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.	
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>JOHNS HOPKINS HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
13a. STATE <b>Maryland</b>		13b. COUNTY		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Mark Warren</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Pattie</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>242-16-8696</b>		17. INFORMANT ADDRESS <b>Massie Wilkerson 2405 Garrison Blvd.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b> <b>5570</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b>INFARCTED BOWEL / SEPSIS</b> (c) <b>THROMBOSIS SMA</b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>24 hrs</b> <b>24 hrs</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) <b>ATTENUSCLEPNOIS</b>							
19a. DATE OF OPERATION <b>12/17/82</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>INFARCTED BOWEL</b>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>12/14</b> , 19 <b>82</b> , to <b>12/17</b> , 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>12/17</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>DANIEL GALYON MD</b>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>12/17/82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DANIEL GALYON MD</b>				22e. ADDRESS <b>518 A. NORTH BOND ST. BALT</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>burial</b>		23b. DATE <b>12/23/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Birchwood Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Roxboro N.C.</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>Wm. C. March F/H Inc, 1101 E. North Avenue</b>				25. DATE RECEIVED BY REGISTRAR <b>DEC 20 1982</b>			

UNITED STATES  
DEPARTMENT OF AGRICULTURE

NO. 1

DATE

YEAR

FIELD NUMBER

CONTAINER NUMBER

STATION

LOCALITY

PLANT

NUMBER

DATE OF COLLECTION

COLLECTOR

PLANT

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
8 2 3 2 0 4 0									
1 - FOR STATE REGISTRAR									
REG. NO.									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST DONALD J. WILLIAMS						2a. DATE OF DEATH MONTH DAY YEAR 12 24 82		2b. HOUR M	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 04 08 38		6. AGE (IN YEARS LAST BIRTHDAY) 44 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENNSYLVANIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.			
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1017 PARKSLEY AVENUE, 21223				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) MARINE, CLERK		12b. KIND OF BUSINESS OR INDUSTRY U.S.M.C.	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE MARYLAND		13b. COUNTY ---		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS UNITED PARCEL SER 1017 PARKSLEY AVENUE, 21223	
14. FATHER'S NAME FIRST MIDDLE LAST JENKIN WILLIAMS				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY PUGH					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 1956-1975		17. INFORMANT ADDRESS MYRA R. WILLIAMS 1017 PARKSLEY AVENUE, 21223					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>lung cancer (squamous cell)</u> 1629 DUE TO, OR AS A CONSEQUENCE OF (b) <u>pneumonia (staphylococcus)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>hypercalcemia, esophageal obstruction</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>December 16, 1982</u> , to <u>December 23, 1982</u> , that (I) (we) last saw the deceased alive on <u>December 23, 1982</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Manuel A. Martin</u>				DEGREE <u>MD</u> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <u>12/27/82</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>MANUEL A MARTIN</u>				22e. ADDRESS <u>WYMAN PARK HOSPITAL</u>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 12-28-82		23c. NAME OF CEMETERY OR CREMATORY NEW CATHEDRAL		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE CITY MARYLAND			
24. FUNERAL DIRECTOR NAME HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVE.				ADDRESS 21229		25a. DATE RECD. BY REGISTRAR DEC 28 1982		25b. REGISTRAR'S SIGNATURE <u>John J. Smith</u>	



13-58-23

NEW ORLEANS

DEPT 8 1938



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

Items 13a-e per phone 12/30/82 dad

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

1- STATE REGISTRAR

CERTIFICATE OF DEATH

REG. NO. 8 2 3 2 0 4 1

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Elmer A. Williams			2a. DATE OF DEATH MONTH DAY YEAR Dec 21 - 1982			2b. HOUR M	
3. SEX Male		4. RACE Col ✓		5. DATE OF BIRTH MONTH DAY YEAR 6 19 81		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 81	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 465 madison ave		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Chauffeur		12b. KIND OF BUSINESS OR INDUSTRY Pvt. Family	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE DEATH) 13b. STATE Maryland		13c. COUNTY Anne Arundel		13d. CITY OR TOWN Patterson		13e. STREET ADDRESS 616 S. Hammonds Ferry Rd.	
14. FATHER'S NAME FIRST MIDDLE LAST Hyland G. Williams		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ginnie Lightcord		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			
16b. SOCIAL SECURITY NO. 112-16-9545		17. INFORMANT ADDRESS Mrs. Blanche Brown - Hammonds Ferry Rd. 616					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Arrest 1629 DUE TO, OR AS A CONSEQUENCE OF (b) Widespread Metastases of DUE TO, OR AS A CONSEQUENCE OF (c) Adenocarcinoma of the Lung.							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a:							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 9-29-81, 19, to 12-21-82, 19, that (I) (we) last saw the deceased alive on 11-22, 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Michael E Klein MD				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12-27-82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Michael E Klein MD				22e. ADDRESS Univ. Md Hospital 225 Green St. 21201.			
23a. BURIAL, CREMATION, REMOVAL (SEE ITEM 18)		23b. DATE 12-24/82		23c. NAME OF CEMETERY OR CREMATORY Mt. Guburn Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Balto - Md.	
24. FUNERAL DIRECTOR NAME Chas. H. Powell				25a. DATE REC'D. BY REGISTRAR DEC 27 1982		25b. REGISTRAR'S SIGNATURE Joan L. Connel	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

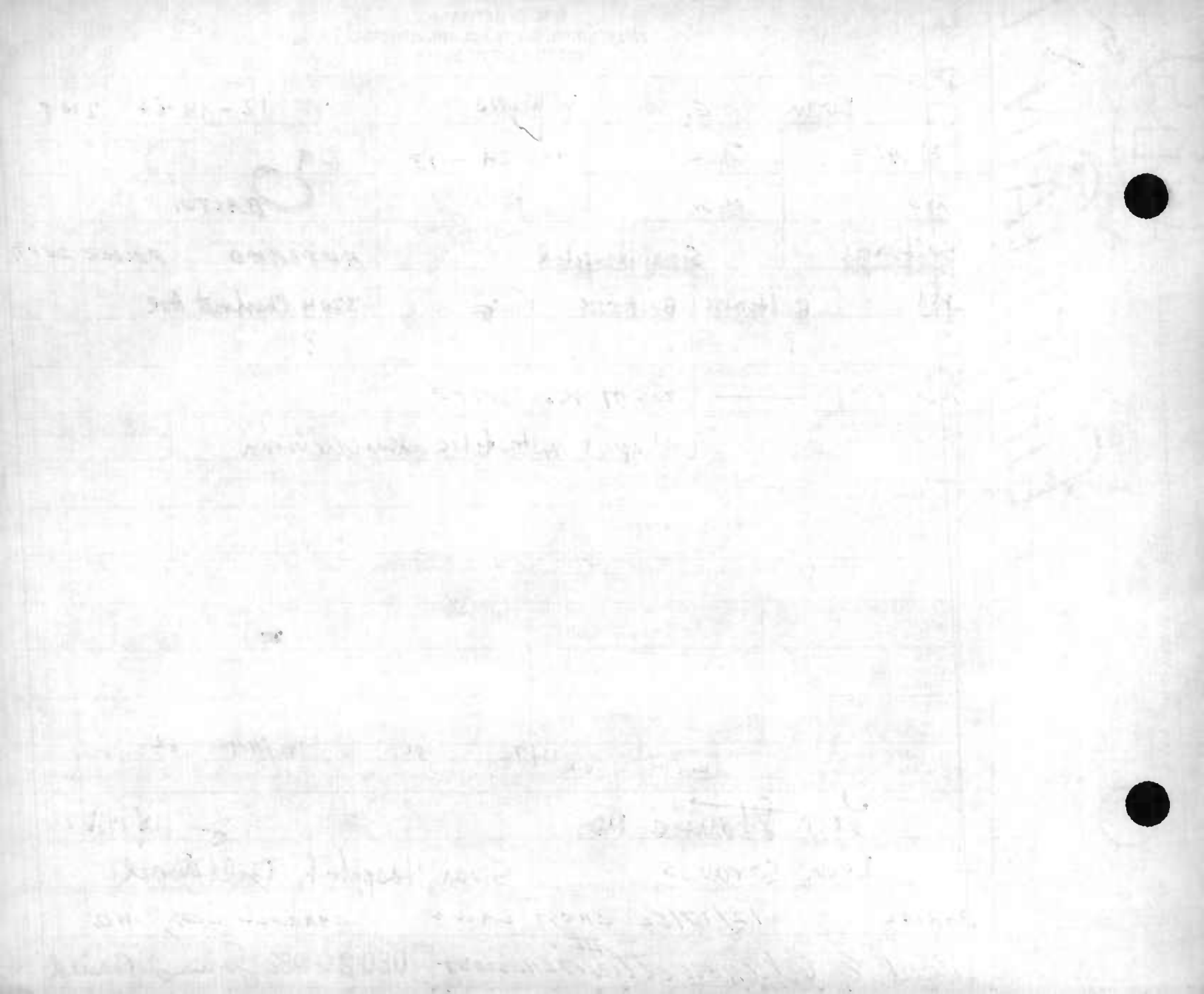
## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
1- FOR STATE REGISTRAR					72 3 2 0 4 2				
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH				
Furn E. Williams					12-14-82				
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE		7b. HOUR	
MALE		Cauc		11-24-13		69		2:30 P.M.	
7a. BIRTHPLACE		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH			
MD		U.S.		NEVER MARRIED		BALTO.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION				12a. USUAL OCCUPATION		12b. KIND OF BUSINESS OR INDUSTRY	
Baltimore		Sinai Hospital				RETIRED		POLICE DEPT.	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
Md		Baltimore		Baltimore		YES		3204 Chestnut Ave	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
FIRST MIDDLE LAST			FIRST MIDDLE LAST						
? ? ?			? ? ?						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS			
NO			215 870 858			WIFE			
18. CAUSE OF DEATH									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY									
IMMEDIATE CAUSE (a) widespread metastatic adenocarcinoma									
DUE TO, OR AS A CONSEQUENCE OF									
(b)									
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
						YES		YES	
21a. ACCIDENT WAS UNDERLYING			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED			
OR CONTRIBUTING CAUSE OF DEATH			HOUR A.M. MONTH DAY YEAR			(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
(IF EITHER, NOTIFY MEDICAL EXAMINER)			P.M.			19			
21d. INJURY OCCURRED			21e. PLACE OF INJURY			21f. LOCATION			
WHILE NOT WHILE			(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			STREET CITY OR TOWN COUNTY STATE			
AT WORK AT WORK									
22a. I certify that (I) (this hospital) attended the deceased from 12/14/82 to 12/14/82, that (I) (we) lost									
saw the deceased alive on 12/14/82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated									
above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE					DEGREE		22c. DATE SIGNED		
Leon Strauss MD					ATTENDING PHYSICIAN		12/14/82		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS				
Leon Strauss					Sinai Hospital Baltimore				
23a. BURIAL, CREMATION, REMOVAL			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		
BURIAL			12/17/82		CREST LAWN		CITY OR TOWN COUNTY STATE		
							CARROLL CO., MD.		
24. FUNERAL DIRECTOR					25a. DATE REC'D. BY REGISTRAR				
Paul E. Cheneveth					DEC 20 1982				
					25b. REGISTRAR'S SIGNATURE				
					John J. Connelley				

BP

DHMH-16.50M.1/BI  
(VRA 15, 4)

1364



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

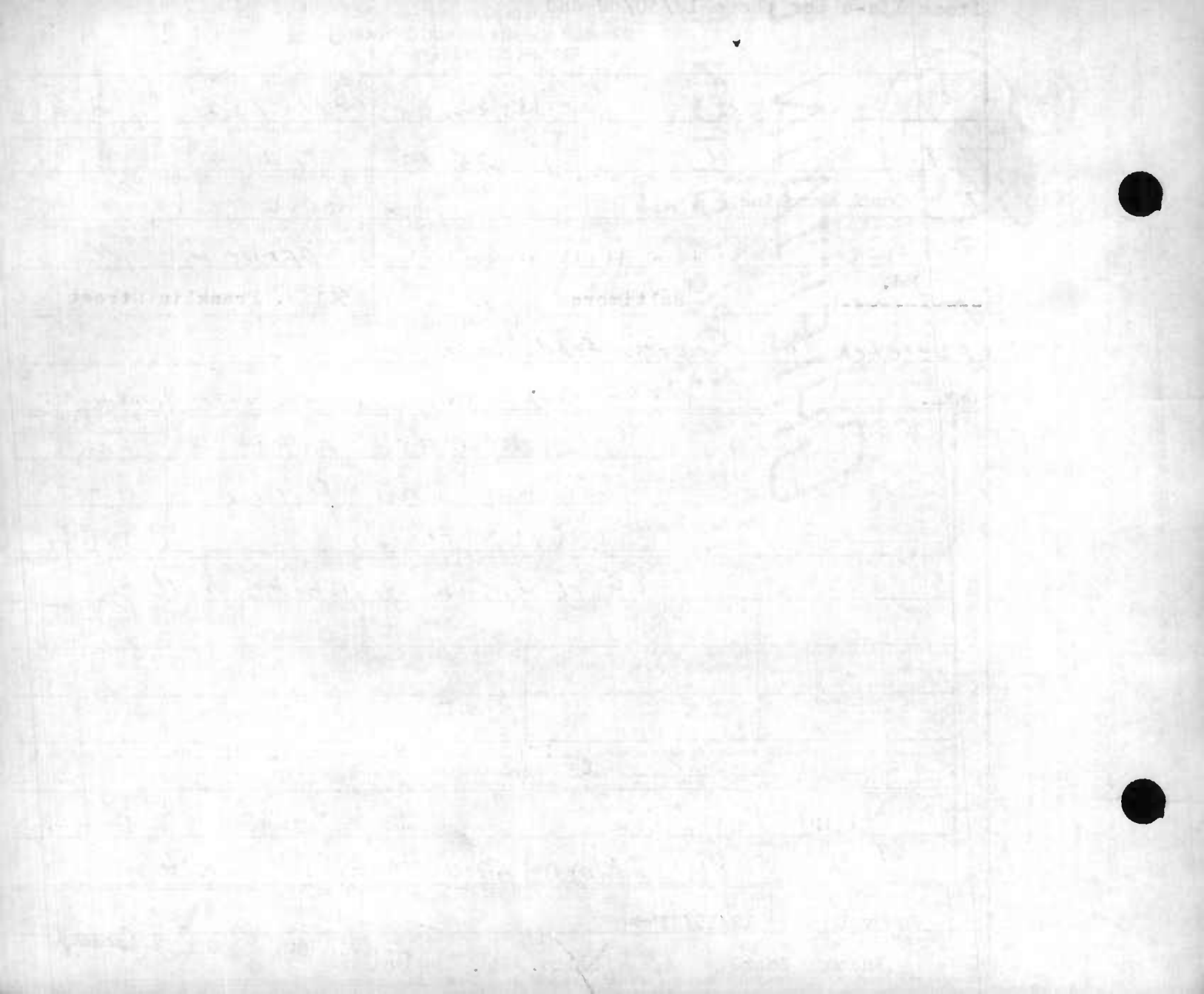
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
REG. NO. 8 2 3 2 0 4 3											
1. DECEASED NAME (TYPE OR PRINT) <b>Evelyn Williams</b>											
2a. DATE OF DEATH MONTH DAY YEAR <b>12/15/82</b> 2b. HOUR <b>2:35</b> MIN. <b>A</b>											
3. SEX <b>F</b> 4. RACE <b>W</b> 5. DATE OF BIRTH MONTH DAY YEAR <b>1 25 10</b> 6. AGE (IN YEARS LAST BIRTHDAY) <b>72</b> YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.											
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>South Carolina</b> 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b> 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Balt. city</b> MD.											
10. CITY OR TOWN OF DEATH <b>Baltimore</b> 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Seton Hill Manor</b> 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>OFFICE W.</b> 12b. KIND OF BUSINESS OR INDUSTRY?											
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE <b>MD</b> 13c. CITY OR TOWN <b>Baltimore</b> 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS <b>501 W. Franklin Street</b>											
14. FATHER'S NAME FIRST MIDDLE LAST <b>Fletcher Wettersford</b> 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Julia</b>											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Unkn.</b> 16b. SOCIAL SECURITY NO. <b>261201391</b> 17. INFORMANT ADDRESS <b>Unknown 501 west Franklin st</b>											
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardio-respiratory arrest</b> 5860 DUE TO, OR AS A CONSEQUENCE OF (b) <b>congestive heart failure</b> (c) <b>kidney failure</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 hrs.</b> <b>4 wks.</b> <b>12 wks.</b>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Hypertension &amp; Diabetes mellitus</b>											
19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b> P.M. 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK 21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE, FARM, ETC.) 21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that (I) (this hospital) attended the deceased from <b>12-15</b> , 19 <b>82</b> , to <b>12-15</b> , 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>12-15</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
27b. SIGNATURE <b>Jaime Punzalan</b> DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> 27c. DATE SIGNED <b>12-15-82</b>											
27d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JAIME PUNZALAN</b> 27e. ADDRESS <b>5214 Hayford W. Balt. Md.</b>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Removal</b> 23b. DATE <b>12/15/82</b> 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION CITY OR TOWN COUNTY STATE											
24. FUNERAL DIRECTOR NAME <b>Anatomy Board</b> ADDRESS <b>Balto., Md.</b> 25a. DATE REC'D. BY REGISTRAR <b>DEC 22 1982</b> REGISTRAR'S SIGNATURE <b>John J. Smith</b>											

BP

DMMH-16 50M 1/81  
(VRA 15, 4)



## CERTIFICATE OF DEATH

REG. NO.

FOR  
1. STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>IRene</b> <b>Williams</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>12-23-82</b>		2b. HOUR <b>M</b>	
3. SEX <b>Female</b>		4. RACE <b>Col.</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>2-23-1891</b>	
6. AGE (IN YEARS LAST BIRTHDAY) <b>91</b>		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Va.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b>		10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Poplar Manor Nursing Home</b>	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY		13a. STREET ADDRESS <b>1509 Poplar Grove St.</b>	
13b. STATE <b>Maryland</b>		13c. CITY OR TOWN <b>BALTO.</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Sohn</b> <b>MEARS</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Martha</b> <b>Rice</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>	
16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>Mr. Heelin Davenport 1509 Poplar Grove St</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cardiopulmonary Arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Ischemic heart disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Arteriosclerotic cardiovascular disease</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that (I) (this hospital) attended the deceased from <b>11-20-82</b> to <b>12-23-82</b> , that (I) (we) lost saw the deceased alive on <b>12-23-82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE <b>MD</b> DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
22c. DATE SIGNED <b>12-24-82</b>		22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>K. NAIR, M.D.</b>		22e. ADDRESS <b>Solo York Rd. BALTIMORE, MD 21212</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>12-28-82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Garden of Eternal Home</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Finkshier</b>		24. FUNERAL DIRECTOR NAME <b>Joseph L. Russ</b> ADDRESS <b>2222 W. North Ave</b>		25a. DATE REC'D. BY REGISTRAR <b>DEC 27 1982</b>	
25b. REGISTRAR'S SIGNATURE <b>John J. Canine</b>					

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



Handwritten signature or text at the bottom left corner.

10/10/2010

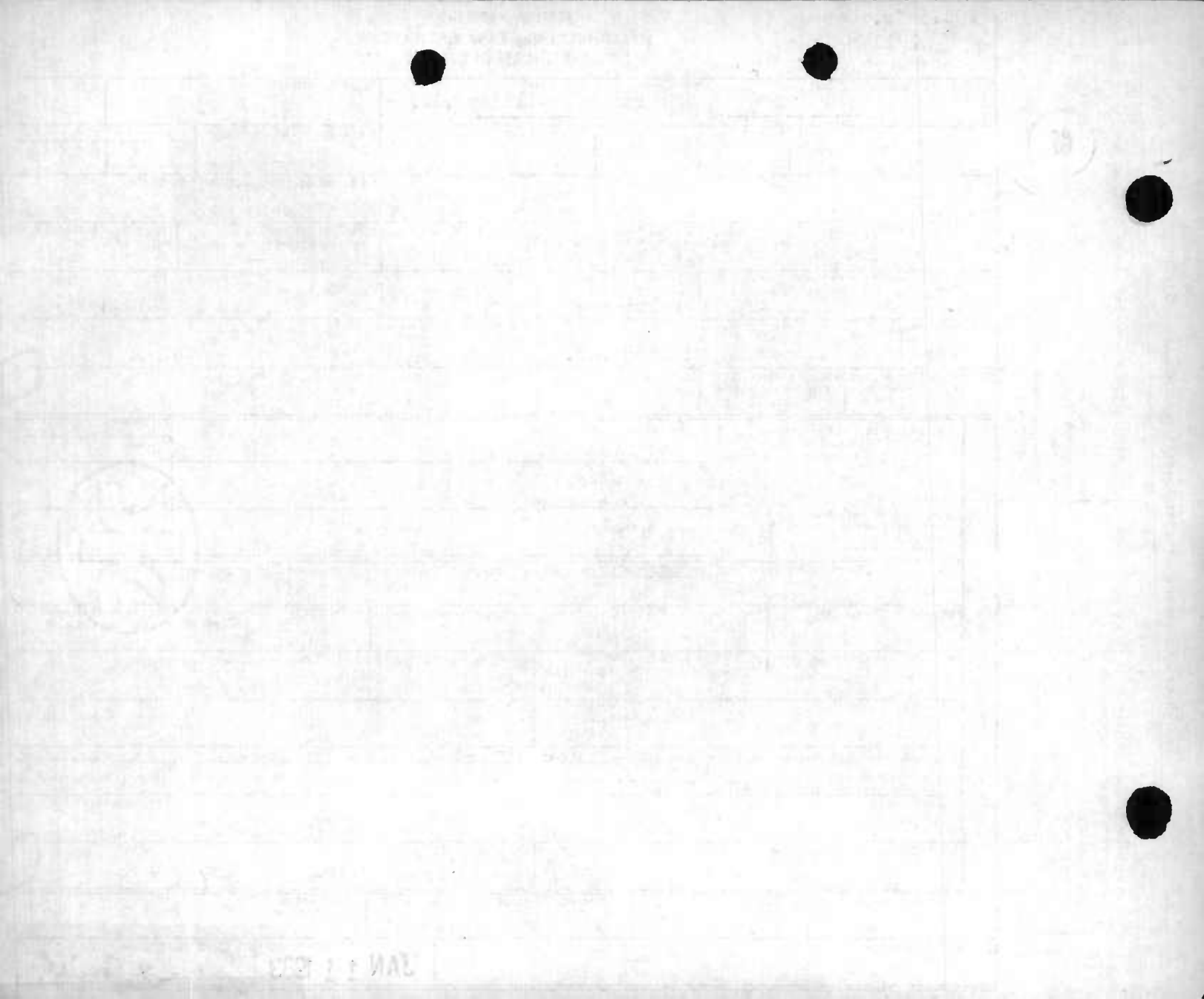


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Add. info. per Birth		STATE OF MARYLAND		DEPARTMENT OF HEALTH AND MENTAL HYGIENE		8 2 3 2 0 4 5	
1. FOR STATE REGISTRAR		1/11/83		CERTIFICATE OF DEATH		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH		MONTH DAY YEAR	
James Robert Williams, III		2b. HOUR		2		15 82	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS (LAST BIRTHDAY))	
male		Black		2 15 82		YRS. MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Maryland, USA		USA				Baltimore city MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Baltimore		University of Md.					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
Md.				Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		13e. STREET ADDRESS		13f. STREET ADDRESS	
FIRST MIDDLE LAST		FIRST MIDDLE LAST		mother		1034 E Pratt St	
James Robert Williams, Jr.		Roslyn					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
				Shuler			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:							
7400 IMMEDIATE CAUSE (a) Cardio Respiratory							
DUE TO, OR AS A CONSEQUENCE OF							
(b) Anencephaly							
DUE TO, OR AS A CONSEQUENCE OF							
(c)							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
		P.M. 19					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from Feb 15, 19 82, to Feb 15, 19 82, that (I) (we) last saw the deceased alive on Feb 15, 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED	
Suzanne Laskar		MD.				2/15/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS					
SUZANNE LASKAR		Univ. Md. Hospital					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Removal		2-15-82		University Hosp			
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
				JAN 11 1983		John J. Connel	



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED IN YOUR FILES. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND										DEPARTMENT OF HEALTH AND MENTAL HYGIENE										MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 3 2 0 4 6									
1. DECEASED NAME (TYPE OR PRINT) <b>James Rudolph Williams</b>										2a. DATE OF DEATH <b>12 5 82</b>										2b. HOUR <b>7:27 AM</b>																			
3. SEX <b>M</b>		4. RACE <b>B</b>		5. DATE OF BIRTH <b>12 26 40</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>41 YRS.</b>		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		2c. DATE PRONOUNCED DEAD <b>12 5 82</b>										2d. HOUR <b>7:27 AM</b>																	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>										7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>										8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b>									
10. CITY OR TOWN OF DEATH <b>Baltimore</b>										11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>University Hospital</b>										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Disabled</b>										12b. KIND OF BUSINESS OR INDUSTRY									
13a. STATE <b>Md</b>										13b. COUNTY <b>Balto.</b>										13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										13e. STREET ADDRESS <b>1606 Vicent Ct.</b>									
14. FATHER'S NAME FIRST MIDDLE LAST <b>Henry Williams</b>										15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>PPearline Lyles</b>										16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>										16b. SOCIAL SECURITY NO.									
17. INFORMANT ADDRESS <b>Shirley Harris 2724 Kinsey Ave.</b>										18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: <b>9660</b> IMMEDIATE CAUSE (a) <b>Stabwound of chest</b> DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).										19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH										21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>1:35 PM 12/5 1982</b>										21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>subject stabbed</b>										21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>									
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>street</b>										21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>NorthAve&amp;SmallwoodSts., Baltimore, MD</b>										22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> .																			
ACTUAL SIGNATURE <b>Margarita A. Korell</b>										M.D. <b>Assistant</b> MEDICAL EXAMINER										DATE SIGNED <b>12/5/82</b>																			
EXAMINER'S NAME (TYPE OR PRINT) <b>Margarita A. Korell, M.D.</b>										ADDRESS <b>111 Penn Street, Balto., MD 21201</b>										23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>										23b. DATE <b>12 10 82</b>									
24. FUNERAL DIRECTOR NAME ADDRESS <b>Brown/Thompson F.H. 1913 W. Balto. St.</b>										23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Calvary Cem</b>										23d. LOCATION CITY OR TOWN COUNTY STATE <b>Glen Burnie A.A.CO Md.</b>										25a. DATE REC'D. BY REGISTRAR <b>DEC 9 1982</b>									
25b. REGISTRAR'S SIGNATURE <b>John J. Connel</b>																																							

RECEIVED  
FEBRUARY 1964



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DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>JOHN T. WILLIAMS</b>			2a. DATE OF DEATH MONTH <b>12</b> DAY <b>6</b> YEAR <b>82</b>			2b. HOUR <b>9:00</b> P.M.									
3. SEX <b>male</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH <b>8</b> DAY <b>28</b> YEAR <b>11</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>71</b> YRS.			IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>			IF UNDER 74 HRS. HOURS <b>0</b> MIN <b>0</b>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.						
10. CITY OR TOWN OF DEATH <b>Baltimore City</b>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Provident Hospital</b>						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Baltimore</b>			13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13d. STREET ADDRESS <b>2117 Ridgehill Ave. 21217</b>						
14. FATHER'S NAME FIRST <b>William</b> MIDDLE <b>Williams</b> LAST <b>Williams</b>						15. MOTHER'S MAIDEN NAME FIRST <b>Regina</b> MIDDLE <b>Garner</b> LAST <b>Garner</b>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO <b>N/A</b>			17. INFORMANT ADDRESS <b>Elizabeth Johnson 2117 Ridgehill Ave</b>									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIO-PULMONARY ARREST</b> <b>2869</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>RENAL FAILURE</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c) <b>COAGULOPATHY</b> DUE TO, OR AS A CONSEQUENCE OF												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 HRS</b> <b>2 HRS</b>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>NO</b>															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (this hospital) attended the deceased from <b>10-12-1982</b> , to <b>12-6-1982</b> , that (I) (we) lost saw the deceased alive on <b>12-6-1982</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) did not view the body after death.															
22b. SIGNATURE <b>RGA ISOLAND MD</b>						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>						22c. DATE SIGNED <b>12-6-82</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>RGA ISOLAND MD</b>						22e. ADDRESS									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b. DATE <b>12/11/82</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Eastview Mem. Pk.</b>			23d. LOCATION CITY OR TOWN <b>Baltimore</b> COUNTY <b>Co.</b> STATE <b>MD</b>						
24. FUNERAL DIRECTOR NAME <b>Wm.C. March F/H Inc.</b>						ADDRESS <b>1101 E. North Avenue</b>						25a. DATE REC'D. BY REGISTRAR <b>DEC 9 1982</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Conner</b>	



*[Faint, illegible handwritten text covering the majority of the page.]*



STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 3 2 0 4 8

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) PEARL R. Williams		2a. DATE OF DEATH MONTH DAY YEAR 12 4 82		2b. HOUR 2:10 PM
3. SEX Female	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR 3 18 14		6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) John Deaton Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE md	13b. COUNTY	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 819 McKim St 21202
14. FATHER'S NAME FIRST MIDDLE LAST Thomas		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie Sheppard		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 212-24-8174		17. INFORMANT Helen Hughes 1835 N Dallas
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PROBABLE SEPSIS 4439 DUE TO, OR AS A CONSEQUENCE OF (b) DRY GANGREN OF RIGHT FOOT DUE TO, OR AS A CONSEQUENCE OF (c) ADVANCED PERIPHERAL VASCULAR DISEASE				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 DAY 2 WEEK 20 YEAR
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a. DIABETES MELLITUS, PAST STROKE				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE
22a. I certify that (I) (this hospital) attended the deceased from NOV 16, 19 82, to DEC 4, 19 82, that (I) (we) lost saw the deceased alive on DEC 3, 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE S. Jackson		DEGREE MD		22c. DATE SIGNED 12/6/82
22d. PHYSICIAN'S NAME (TYPE OR PRINT) FRANK R. JACKSON MD		22e. ADDRESS J. L. DEATON CTR BALTO MD		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 12/10/82	23c. NAME OF CEMETERY OR CREMATORY King Memorial Pk.	23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Co. Md.
24. FUNERAL DIRECTOR NAME Wm. C. March F/H Inc. 1101 E. North Ave.		25a. DATE REC'D. BY REGISTRAR DEC 7 - 1982		
		25b. REGISTRAR'S SIGNATURE John J. Canfield		

MEDICAL CERTIFICATION

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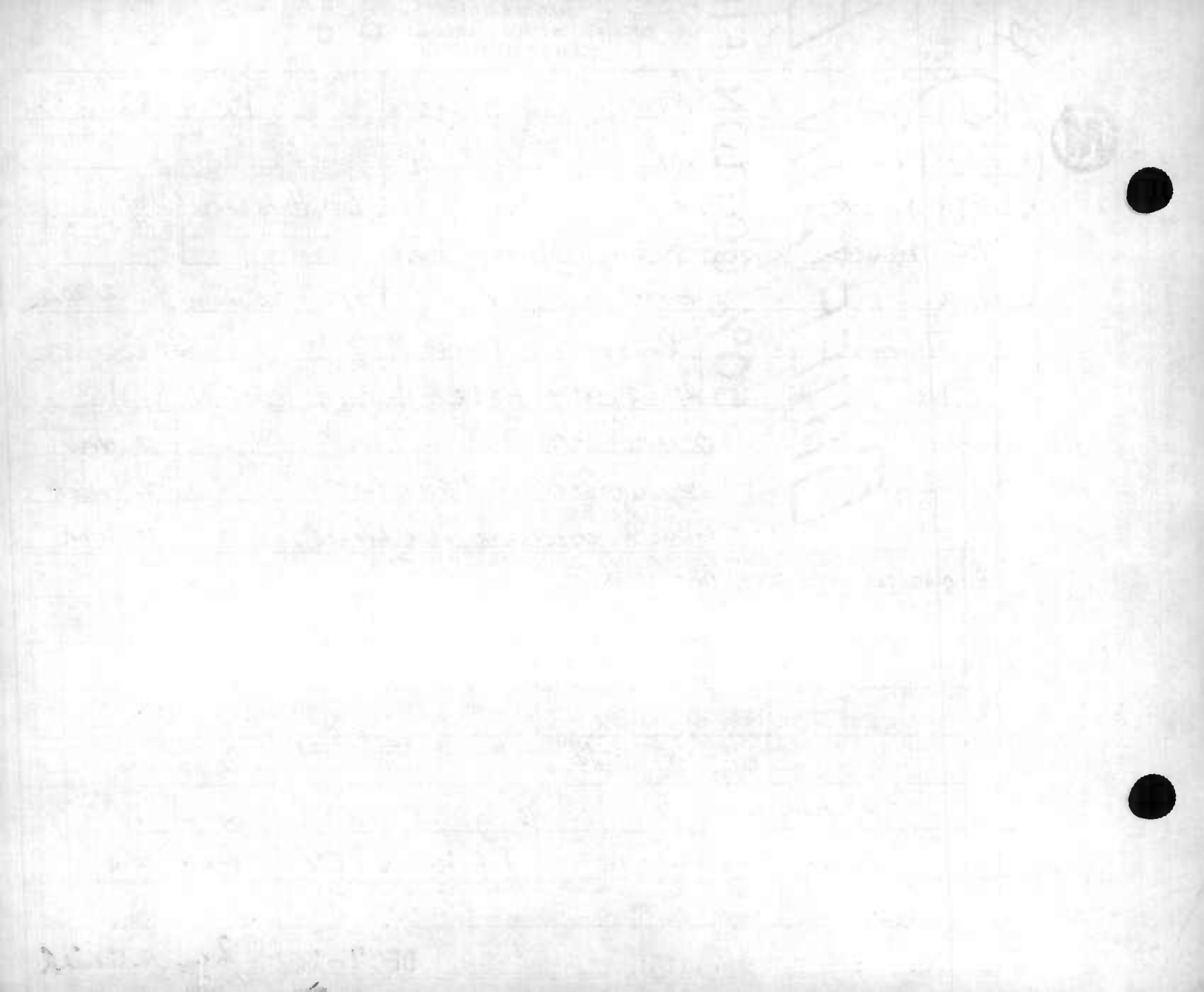
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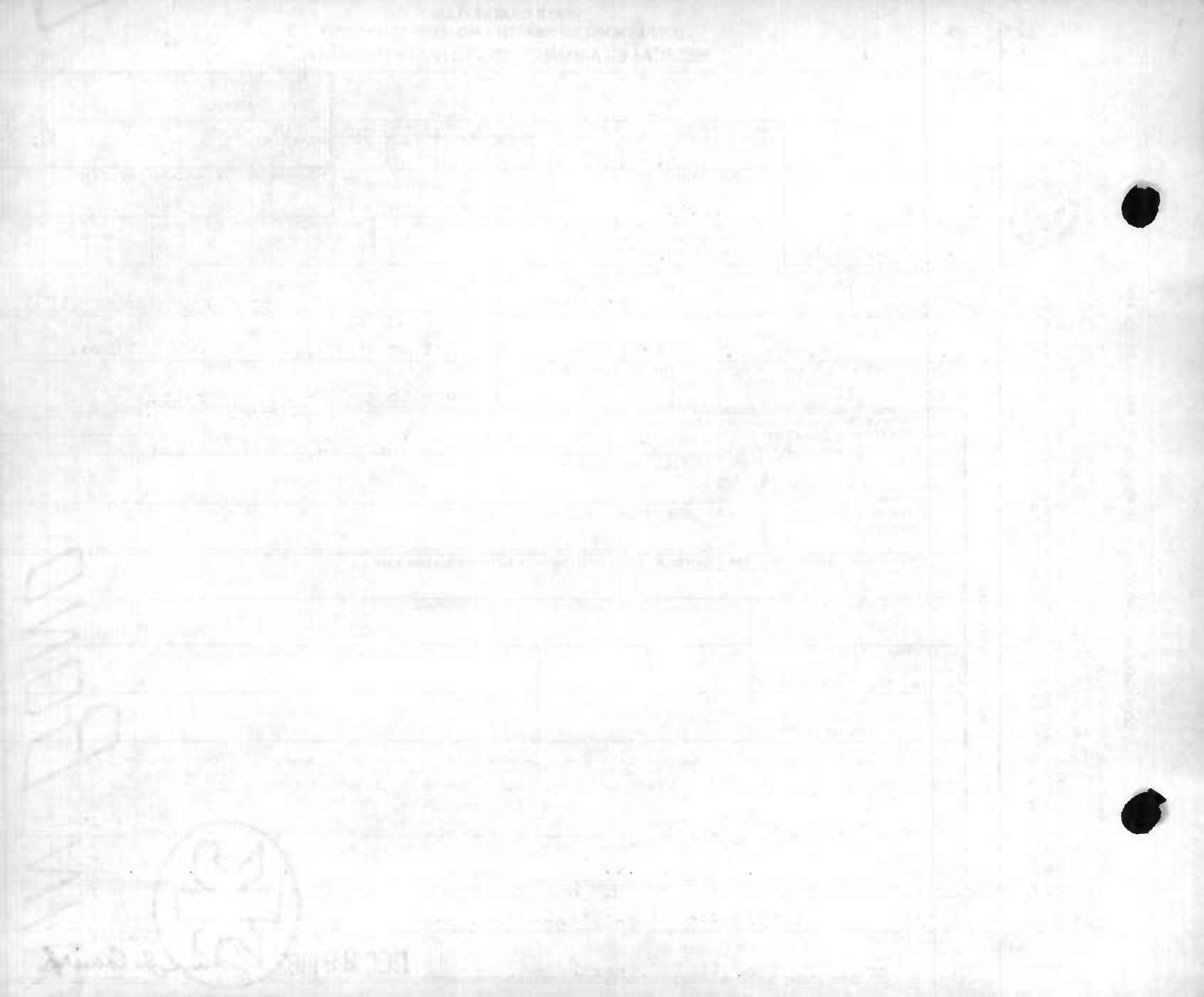
9





TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 3 2 0 4 9	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST RUTH C. WILLIAMS								2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 12 26 19 82		2b. HOUR M 8:53	
3. SEX female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 6 8 25		6. AGE (IN YEARS) LAST BIRTHDAY 57 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 12 26 19 82	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Atlanta, Ga.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City				MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Church Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Maryland		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 219 South Spring Court 21231			
14. FATHER'S NAME FIRST MIDDLE LAST J. B. Latimore				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Est er Latimore							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no				16b. SOCIAL SECURITY NO. N/A		17. INFORMANT ADDRESS Veora Wade 2410 E. Eager St.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 4029 IMMEDIATE CAUSE (a) Hypertensive cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <i>Ann M. Dixon</i>				TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER				DATE SIGNED 12-27-82			
EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D.				ADDRESS 111 Penn St., Balto., Md. 21201							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 12/30/82		23c. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.			
24. FUNERAL DIRECTOR NAME ADDRESS Wm. C. March F/H Inc. 1101 E. north Ave.						25a. DATE REC'D. BY REGISTRAR DEC 29 1982		25b. REGISTRAR'S SIGNATURE <i>John J. Camick</i>			



1- FOR  
STATE  
REGISTRAR

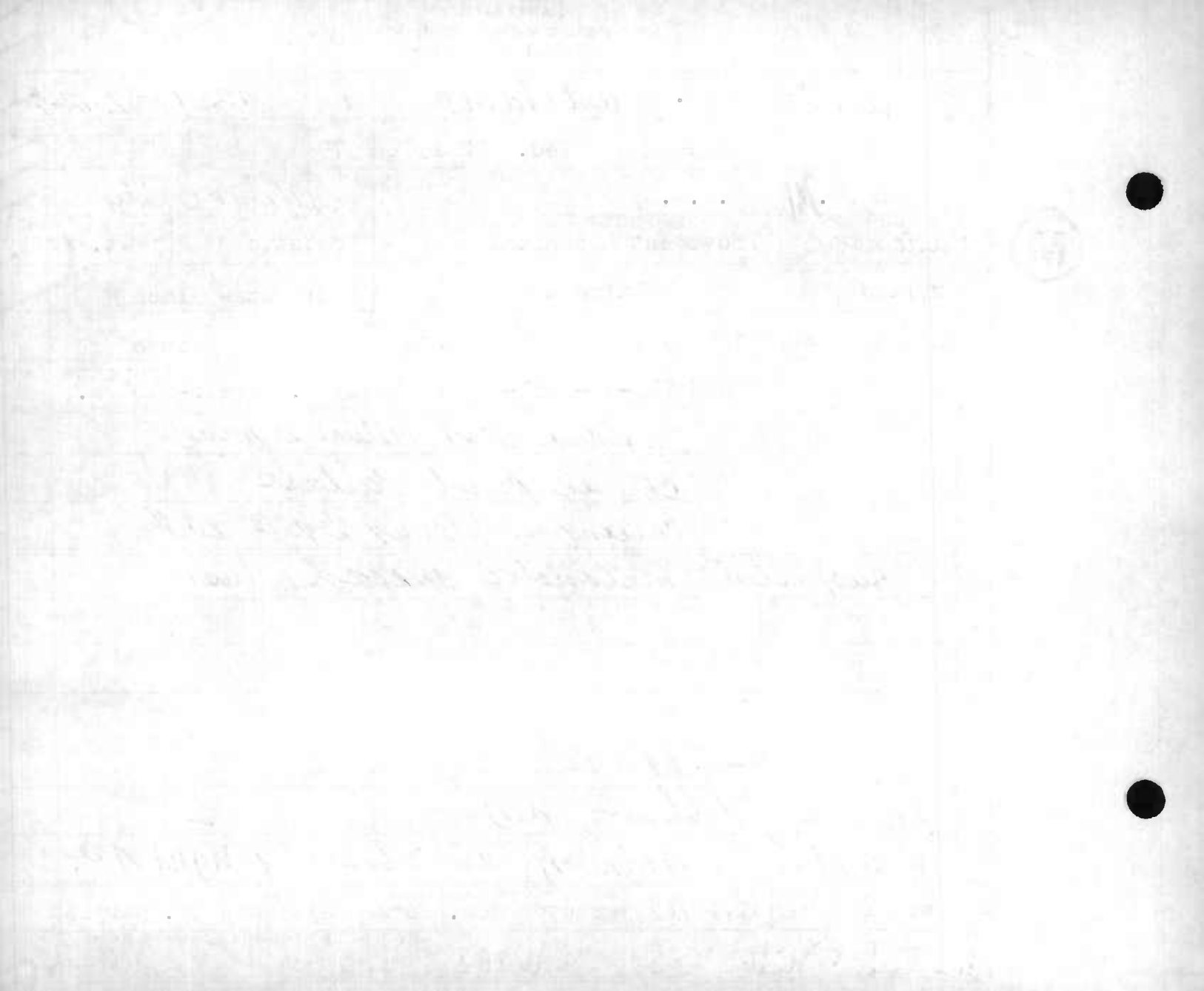
1 DECEASED NAME (TYPE OR PRINT) <i>Sussie E. Williams</i>			2a DATE OF DEATH MONTH DAY YEAR <i>12-17-82</i>			2b HOUR <i>12:45</i> M			
3 SEX <i>Female</i>		4 RACE <i>Black</i>		5 DATE OF BIRTH MONTH DAY YEAR <i>Dec. 22 1902</i>		6 AGE (IN YEARS LAST BIRTHDAY) <i>79</i>		7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
8 BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Howard CO. MD</i>		7b CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City</i> MD.			
10 CITY OR TOWN OF DEATH <i>Baltimore</i>		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION <i>Provident Hospital</i>				12a USUAL OCCUPATION (TYPE OF WORK FORMOST OF WORKING LIFE) <i>Domestic</i>		12b KIND OF BUSINESS OR INDUSTRY <i>Pvt. Family</i>	
13a STATE <i>Maryland</i>		13b COUNTY		13c CITY OR TOWN <i>Baltimore</i>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS <i>1701 Eutaw Place</i>	
14 FATHER'S NAME FIRST MIDDLE LAST <i>Charles Marshall Bias</i>				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Luvia Jones</i>					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>				16b SOCIAL SECURITY NO. <i>213-18-1851</i>		17. INFORMANT ADDRESS <i>Lafayette Ave</i> <i>Miss Daisy E. Harris-2506 W.</i>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Congestive Heart failure 2° ASCVD</i> 1809 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (b) <i>Chronic Renal failure</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Coronary of Cervix stage IV with</i> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <i>Suspected metastatic spread to liver</i>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from <i>Dec. 17</i> 19 <i>82</i> , to <i>19</i> , that (I) (we) last saw the deceased alive on <i>Dec. 17</i> 19 <i>82</i> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death.									
22b SIGNATURE <i>Franklin Addison, MD</i>						DEGREE <i>MD</i>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Franklin J. Addison</i>						22e. ADDRESS <i>2600 Liberty Hght Ave.</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>			23b. DATE <i>12/22/82</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Arbutus Mem. Park</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Baltimore Co. Maryland</i>		
24. FUNERAL DIRECTOR NAME <i>Herbert E. Nutt</i>						ADDRESS <i>3035 W. North Ave.</i>		25a. DATE REC'D. BY REGISTRAR <i>DEC 20 1982</i>	
						25b. REGISTRAR'S SIGNATURE <i>Jan J. Conish</i>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained by the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 48 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 3 2 0 5 1	
1- DECEASED NAME (TYPE OR PRINT) <b>Willie Williams</b>										2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <b>12 24 19 82</b>	
3. SEX <b>Male</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>7 20 23</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>59 YRS.</b>		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		2c. DATE PRONOUNCED DEAD <b>12 24 19 82 11:30</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>N.C.</b>				7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b>	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>415 Oxford Court</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Md.</b>		13b. COUNTY		13c. CITY OR TOWN <b>Balto.</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>415 Oxford Ct. 21201</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Paul Williams</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Phonie Williams</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. <b>238-26-5246</b>		17. INFORMANT ADDRESS <b>Bobby Horton 918 E. Lombard St.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> <b>4292</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <b>[Signature]</b>				TITLE (SPECIFY) <b>Assistant</b>				DATE SIGNED <b>12/25/82</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>Hormez R. Guard, M.D.</b>				ADDRESS <b>111 Penn Street, Balto. MD 21201</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>1/2/83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Bush Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Rocky Point, N.C.</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>Wm C March F/H 1101 E. North Ave.</b>						25a. DATE REC'D. BY REGISTRAR <b>JAN - 3 1983</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 3 2 0 5 2

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) BERTHA Mae WILLIAMSON			2a. DATE OF DEATH MONTH DAY YEAR 12-31-82		2b. HOUR 4:55 P. M.
3. SEX FEMALE	4. RACE BLACK	5. DATE OF BIRTH MONTH DAY YEAR 4 6 04		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE County City MD.	
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SINAI HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED - Sec.		12b. KIND OF BUSINESS OR INDUSTRY Agency Employment
13a. STATE MD		13b. COUNTY BALTIMORE	13c. CITY OR TOWN BALTIMORE	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 3018 TIOGA PARKWAY
14. FATHER'S NAME FIRST MIDDLE LAST Peter Morris			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Addie Smith		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 213-12-3061		17. INFORMANT ADDRESS Mrs. Sylvia White-3018 Tioga Pkwy. 21215	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SUPERIOR VENA CAVA SYNDROME DUE TO, OR AS A CONSEQUENCE OF (b) LEIOMYOSARCOMA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 MRS.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: no					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 12-30, 19 82, to 12-31, 19 82, that (I) (we) last saw the deceased alive on 12-31, 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Jerome E. Covington			DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 12-31-82
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jerome E. Covington			22e. ADDRESS SINAI Hospital		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE Jan 5, 1983	23c. NAME OF CEMETERY OR CREMATORY Arbutus Mem. Pk.		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Co. Maryland	
24. FUNERAL DIRECTOR NAME Herbert E. Hutter - 3035 W. North Ave.			25a. DATE REC'D. BY REGISTRAR JAN 5 1983		
			25b. REGISTRAR'S SIGNATURE John J. Hutter		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified about it.

H. C. ...

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 10 days after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
1 - STATE REGISTRAR									
CERTIFICATE OF DEATH									
REG. NO.									
1. DECEASED NAME (TYPE OR PRINT) JAMES M. WILLING					2a. DATE OF DEATH MONTH DAY YEAR 12/26/82			2b. HOUR 11:00 AM	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 1-26-1903		6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS		7. IF UNDER 1 YEAR MONTHS DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore MD.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St Agnes Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Baker		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE Md					13c. CITY OR TOWN Catonville		13d. STREET ADDRESS 98 Smithwood Ave		
14. FATHER'S NAME FIRST MIDDLE LAST George W. W. Willing					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Maggie E. Willing				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No					16b. SOCIAL SECURITY NO. 215-05-4142		17. INFORMANT 6000 Park Rd, Catonsville, Md 21228		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Low output CHF 4292 DUE TO, OR AS A CONSEQUENCE OF (b) ASCVD Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) COPD. Renal failure									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 12/25 1982, to 12/26 1982, that (I) (we) last saw the deceased alive on 12/26 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Bui T Duong, M.D.					DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED 12/26/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BICH DUONG, M.D.					22e. ADDRESS Baltimore, Md				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 12/29/82		23c. NAME OF CEMETERY OR CREMATORY Bivale Cemetery		23d. LOCATION Bivale, Md		
24. FUNERAL DIRECTOR James Bivale, Md					25. DAY REC'D BY REGISTRAR DEC 30 1982				



3

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 3 2 0 5 4	
1. FOR STATE REGISTRAR										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>ELGIN EUGENE WILLS</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>12 6 82</b>			2b. HOUR <b>2:55 P</b>			
3 SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Aug. 29, 1923</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>59</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>1501 S. Charles Street</b> MD.					
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Bon Secours Hospital</b>				12a. USUAL OCCUPATION (TYPE OR WORK FOR MOST OF WORKING LIFE) <b>Painter</b>		12b. KIND OF INDUSTRY <b>House Painting</b>			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
13a. STATE <b>Maryland</b>		13b. COUNTY <b>= = =</b>		13c. CITY OR TOWN <b>Baltimore</b>		13e. STREET ADDRESS <b>1501 S. Charles Street</b>					
14. FATHER'S NAME FIRST MIDDLE LAST <b>Charles = Wills</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Viola = McGuire</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. <b>227-16-7172</b>		17. INFORMANT <b>Terry Wills</b>		ADDRESS <b>1600 S. Charles St.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac arrest</b> <b>4254</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Congestive cardiomyopathy.</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Pneumonia, sepsis, inanition, GI bleeding, UTI, decubitus</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (if this hospital) attended the deceased from <b>11/1</b> , 19 <b>82</b> , to <b>12/6</b> , 19 <b>82</b> , that (b) (we) lost saw the deceased alive on <b>12/6</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (if we did not view the body after death).											
22b. SIGNATURE <b>Christopher H. Coulter</b>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>12/6/82</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Coulter</b>		22e. ADDRESS <b>Bon Secours Hospital.</b>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>12/8/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Westview Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Catonsville, Balto. Md.</b>					
24. FUNERAL DIRECTOR NAME <b>Raymond C. Fink</b>				ADDRESS <b>Glen Burnie, Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>DEC 8 1982</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Canine</b>			



Received of the  
 Treasurer of the  
 City of  
 the sum of  
 \$100.00  
 for  
 the  
 year  
 1900

This receipt is valid only when countersigned by the  
 Treasurer of the City of

City of

1900

1900



1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <i>Mildred Wilmore</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>12/14/82</i>			2b. HOUR <i>1:05 PM</i>					
3 SEX <i>Female</i>		4. RACE <i>Black</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>11/15/04</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>78</i> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.	
9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Bmth. City</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U. S. A</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore, City</i> MD					
10. CITY OR TOWN OF DEATH <i>Bmth. City</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Grant Ventr Ave Nursing Home</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>retiree</i>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <i>MD</i>				13b. COUNTY <i>Bmth.</i>		13c. CITY OR TOWN <i>Bmth.</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST <i>Wmth.</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Wmth.</i>				16. ADDRESS <i>3609 Fairview Ave</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>				16b. SOCIAL SECURITY NO. <i>216-50-1440</i>		17. INFORMANT ADDRESS <i>Nursing Home Records 607 Redd. Ave</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebro-vascular accident</i> <i>4360</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Hypertension</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) <i>Heart failure</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION <i>11-19-82</i>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Heart failure</i>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>19</i>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <i>11-19-82</i> to <i>12-14-82</i> , that (I) (we) last saw the deceased alive on <i>12-14-82</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>R.O. Crostey</i>						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>R.O. CROSTHEY</i>						22e. ADDRESS <i>1235 E. Monument St Balto Md</i>					
23a. BURIAL, CREMATION, REMOVAL (Type)			23b. DATE <i>12/23/82</i>			23c. NAME OF CEMETERY OR CREMATORY <i>Mt. Calvary Cem</i>			23d. LOCATION CITY OR TOWN COUNTY STATE <i>A. B. County Ave.</i>		
24. FUNERAL DIRECTOR <i>Irvin P. Carroll</i>						1712 W. North Ave. Balto., Md.			25a. DATE REC'D. BY REGISTRAR <i>DEC 17 1982</i>		
						25b. REGISTRAR'S SIGNATURE <i>John J. Carver</i>					





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 3 2 0 5 6

FOR  
1- STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>HELENA WILSON</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>12 25 82</b>		2b. HOUR <b>6:04 PM</b>	
3 SEX <b>FEMALE</b>	4 RACE <b>Black</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>9 30 1898</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>94</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.	
10. CITY OR TOWN OF DEATH <b>BALTIMORE CITY</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>PROVIDENT HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE <b>Maryland</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>George Johnson</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary</b>		13e. STREET ADDRESS <b>1234 Darley Avenue 21218</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>N/a</b>		17. INFORMANT ADDRESS <b>George Wilson Jr. 1234 Darley Avenue</b>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardio Respiratory Arrest</b> <b>2500</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Diabetes Mellitus</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Diabetes Mellitus CVA</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)		

## MEDICAL CERTIFICATION

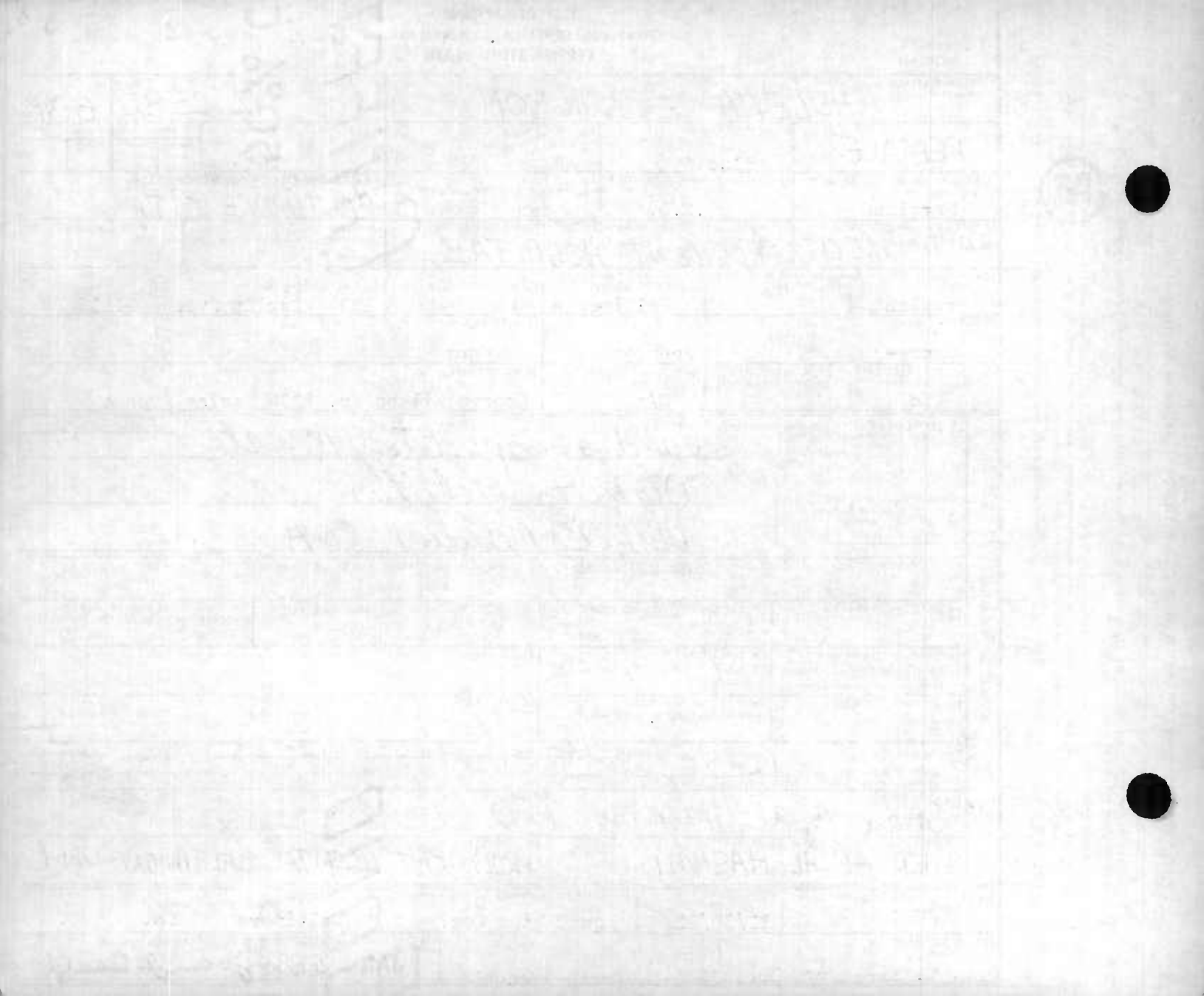
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>12-21</b> , 19 <b>82</b> , to <b>12-25</b> , 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>12-25</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Sher Afzal Hashmi MD</b>				DEGREE <b>MD</b>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>SHER AFZAL HASHMI</b>				22e. ADDRESS <b>PROVIDENT HOSPITAL BALTIMORE Md</b>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>12/30/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mount Zion Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Co. Md.</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>Wm. C. March F/h Inc. 1101 E. North Avenue</b>				25a. DATE REC'D. BY REGISTRAR <b>JAN - 3 1983</b>		25b. REGISTRAR'S SIGNATURE <b>Joan J. Conner</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Registrar after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8 2 3 2 0 5 7					
1. FOR STATE REGISTRAR										2a. DATE OF DEATH MONTH DAY YEAR				2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Henry C. Wilson										December 11, 1982				10:26 AM	
3 SEX male			4 RACE Black			5. DATE OF BIRTH MONTH DAY YEAR 8 4 23			6. AGE (IN YEARS LAST BIRTHDAY) 59 YRS.			IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.						
10. CITY OR TOWN OF DEATH Baltimore			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Maryland General Hospital						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Maryland			13b. COUNTY			13c. CITY OR TOWN Baltimore			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 2435 Woodbrook Ave. 21217			
14. FATHER'S NAME FIRST MIDDLE LAST Edgar Wilson						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bessie Bell									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 215-16-6101			17. INFORMANT ADDRESS Ida C. Wilson 2435 Woodbrook Avenue									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary Demise</u> 4410 DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 Hours															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Status Post - Dissecting Aortic Aneurysm Repaired On 12/9/82.															
19a. DATE OF OPERATION 12/9/82			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Dissecting Abdominal Aneurysm				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from December 9, 1982, to December 11, 1982, that (I) (we) lost saw the deceased above December 11, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (not) view the body after death.															
22b. SIGNATURE Daniel Schwartz MD						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED 12/11/82						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Daniel Schwartz MD						22e. ADDRESS c/o Maryland General Hospital									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 12/16/82			23c. NAME OF CEMETERY OR CREMATORY Eastview Memorial Pk.			23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Co. Md.						
24. FUNERAL DIRECTOR NAME Wm. C. March F/H Inc. 1101 E. North Avenue						25a. DATE REC'D. BY REGISTRAR DEC 13 1982			25b. REGISTRAR'S SIGNATURE John J. Connelley						



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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 3 2 0 5 8

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Howard Wilson</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>12-14-82</b>		2b. HOUR <b>1:30 PM</b>
3. SEX <b>male</b>	4. RACE <b>Black</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>10 07 10</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>72</b> RS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Lafayette Square Nsg. Center</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b></b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltio-</b>		13c. STREET ADDRESS <b>2311 Roslyn Avenue</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b></b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b></b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b></b>	
16b. SOCIAL SECURITY NO. <b>164165131m</b>		17. INFORMANT ADDRESS <b></b>			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

**RECTAL BLEEDING**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

(b)

**METASTATIC CARCINOMA LUNG**

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>12/10</b> , 19 <b>82</b> , to <b>12/14</b> , 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>12/10</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>M. P. B.</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>12/14</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>M. P. B.</b>		22e. ADDRESS <b>2717-Hammocks Ferry Rd BALTO 21227</b>			

23a. BURIAL, CREMATION, REMOVAL <b>Burial</b>	23b. DATE <b>12/28/82</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Carmel C.</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>A. A. Courty M.</b>
24. FUNERAL DIRECTOR NAME ADDRESS <b>1212 W. North</b>		25a. DATE REC'D. BY REGISTRAR <b>DEC 17 1982</b>	

1912/10/29



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, immediate notification must be made to the State Dept. of Health and Mental Hygiene.

DHMH - 1650M 1/81  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 3 2 0 5 9

1. FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>FLA. ESTELLE WILSON</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>Dec 17<sup>th</sup> 82</b>		2b. HOUR <b>430p<sup>m</sup></b>
3. SEX <b>Female</b>	4. RACE <b>white</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>4 2 28</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>54</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>NORTH CAROLINA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTO CITY MD.</b>	
10. CITY OR TOWN OF DEATH <b>BALTO</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>BALTO CITY HOSP.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>H/W</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE <b>MD</b> COUNTY <b>BALTO</b>		13b. CITY OR TOWN <b>DUNDALK</b>		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST <b>SOLOMON</b> MIDDLE <b>GARNER</b> LAST <b>ANNIE</b>		15. MOTHER'S MAIDEN NAME FIRST <b>ANNIE</b> MIDDLE <b>-</b> LAST <b>-</b>		16. STREET ADDRESS <b>1909 AUGUST AVE.</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>237-38-6628</b>		17. INFORMANT <b>CURTIS WILSON</b> ADDRESS <b>SAME</b>	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: <b>4360 IMMEDIATE CAUSE (a) Cardiorespiratory arrest.</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
DUE TO, OR AS A CONSEQUENCE OF (b) <b>Cerebrovascular Accident</b>					
DUE TO, OR AS A CONSEQUENCE OF (c) <b>Hypertension / Rheumatic heart disease</b>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>ext 1<sup>st</sup></b> , 19 <b>82</b> , to <b>Dec 17<sup>th</sup></b> , 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>Dec 17<sup>th</sup></b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>P. NIKOOMANESH</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>2/22/82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>PARVIZ NIKOOMANESH</b>		22e. ADDRESS <b>4940 Eastern Ave. Balto. MD</b>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>	23b. DATE <b>12/20/82</b>	23c. NAME OF CEMETERY OR CREMATORY <b>HOLLY HILL</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTO MD</b>
24. FUNERAL DIRECTOR NAME <b>CONNELLY FUNERAL HOME OF DUNDALK</b>		25a. DATE REC'D. BY REGISTRAR <b>DEC 21 1982</b>	25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>

~~Agathidium~~

5510-25

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
Item 18a&b 20 thru 22a 1- FOR STATE REGISTRAR 2-17-84 cn CERTIFICATE OF DEATH									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>KATHLEEN R. WILSON</b>						2a. DATE OF DEATH MONTH DAY YEAR <b>12 11 82</b>		2b. HOUR <b>9<sup>30</sup> P.M.</b>	
3. SEX <b>Female</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>10 29 1900</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>82 YRS.</b>		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New York</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.			
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>UNION MEMORIAL HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Maryland</b>						13b. COUNTY <input checked="" type="checkbox"/>		13c. CITY OR TOWN <b>Baltimore</b>	
13d. INSIDE CITY LIMITS? <b>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></b>						13e. STREET ADDRESS <b>2944 Harford Rd. 21218</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Marshall Morris</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Kaltheen</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. <b>215-16-2345</b>		17. INFORMANT ADDRESS <b>Alva Ballard 2944 Harford Road</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: <b>2500 IMMEDIATE CAUSE (a) C. Fracture</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) <b>ADDM</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Depressing; fall down steps</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>DIABETES SARCINAL DECURATI</b>									
19a. DATE OF OPERATION <b>9-20-82</b>				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? <b>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></b>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? <b>YES <input type="checkbox"/> NO <input type="checkbox"/></b>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 9-20-82 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) <b>Foot shipped down steps &amp; fell</b>			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <b>Home</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>11/12</b> , 19 <b>82</b> , to <b>12/11</b> , 19 <b>82</b> , that (I) (we) lost the deceased alive on <b>12/11</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. <b>Natural</b>									
22b. SIGNATURE <b>Vincent A. DiPietro M.D.</b>						22c. DATE SIGNED <b>12/11/82</b>		22d. ADDRESS <b>UNION MEMORIAL HOSPITAL</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>				23b. DATE <b>12/16/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Pleasant Rest Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Co. Md.</b>	
24. FUNERAL DIRECTOR NAME <b>Wm. C. March F/H Inc. 1101 E, North Avenue</b>						25. DATE RECEIVED BY REGISTRAR <b>DEC 13 1982</b>		26. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

BP 460

FORM 16-50M (1/81)  
(VRA 15, 4)



WILSON R. HOSPITAL

BALTIMORE CITY

WILSON R. HOSPITAL

BALTIMORE



WILSON R. HOSPITAL

VINCENT A. DIPETRO

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified promptly.

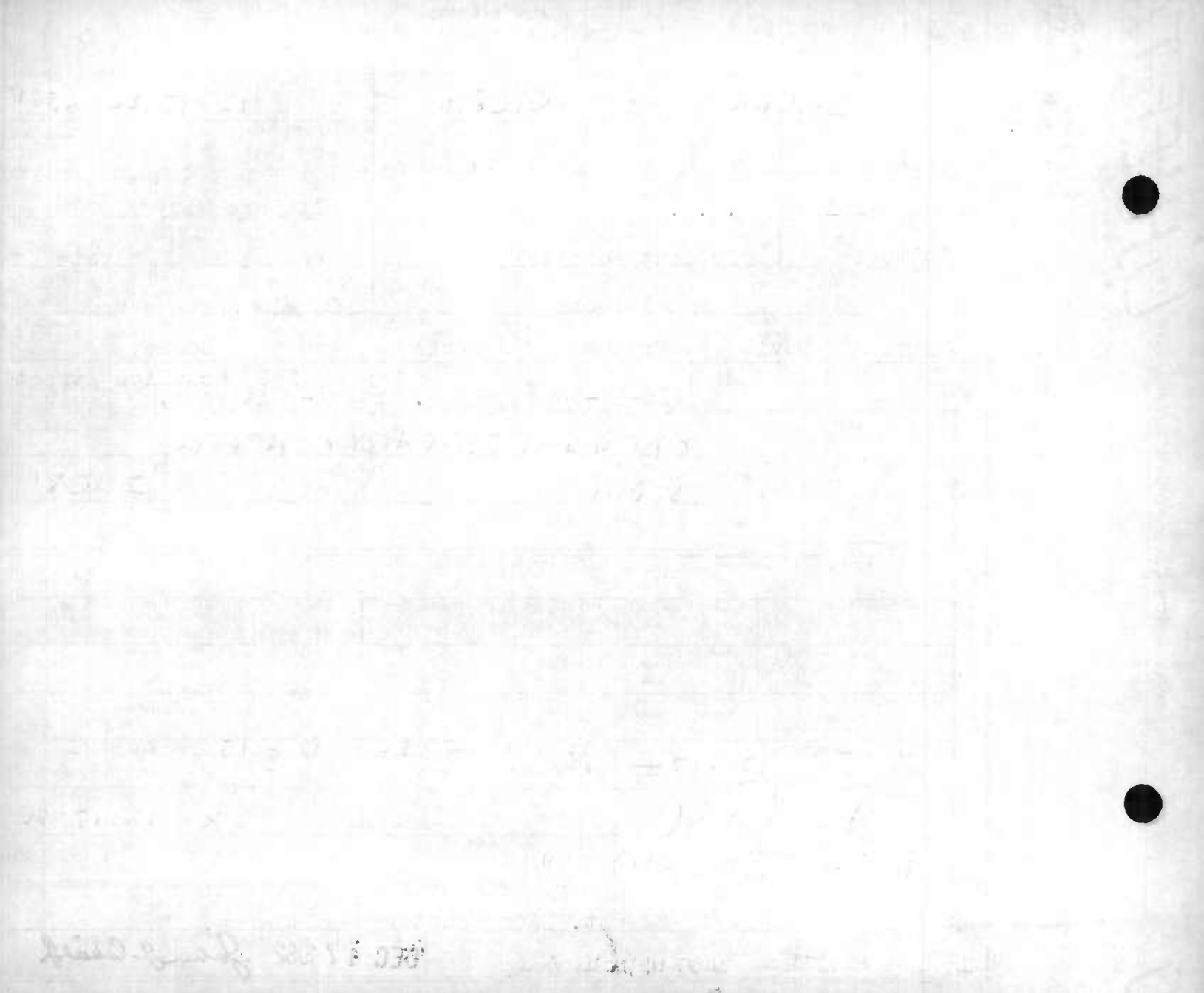
FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>LAURA AMELIA WILSON</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>12 13 82</b>		2b. HOUR <b>630 P M</b>	
3. SEX <b>FEMALE</b>	4. RACE <b>BLACK</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>June 9, 1900</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>82</b> YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>South Carolina</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Provident Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Nurse</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Private</b>
13a. STATE <b>MD</b>		13b. COUNTY <b>Baltimore</b>	13c. CITY OR TOWN <b>Baltimore</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>John David Franks</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Carrie Ann Coasey</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>216-16-3664</b>		17. INFORMANT ADDRESS <b>2523 McCulloh Street Lola B. Franks-Baltimore, MD 21216</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIO-RESPIRATORY ARREST</b> <b>0389</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b>SEPSIS</b> (c) <b>DUE TO, OR AS A CONSEQUENCE OF</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 WKS</b>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):					
19a. DATE OF OPERATION <b>9 9</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that <del>the</del> (this hospital) attended the deceased from <b>12-2-1982</b> to <b>12-13-1982</b> , that <del>the</del> (we) last saw the deceased alive on <b>12-13-1982</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>RGA. BOLAND M.D.</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>12-13-82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>RGA. BOLAND M.D.</b>		22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>12/18/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Zion Cemetery</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, MD</b>		24. FUNERAL DIRECTOR NAME ADDRESS <b>Hubert E. Hutter 3035 W. North Ave.</b>			
25a. DATE REC'D. BY REGISTRAR <b>DEC 17 1982</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Connel</b>			

BP



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>MATTIE WILSON</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>12 23 82</b>		2b. HOUR <b>M</b>
3. SEX <b>FEMALE</b>	4. RACE <b>BLACK</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>8 29 14</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>68</b> YRS MONTHS DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>VIRGINIA</b>	7b. CITIZEN OF WHAT COUNTRY? <b>US</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>CITY</b> MD.	
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>LUTHERAN HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>BEAUTICIAN</b>		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE <b>MARYLAND</b>			13b. COUNTY	13c. CITY OR TOWN <b>BALTIMORE</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST <b>COLUMBUS OLIVER</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>LOTTIE KNIGHT</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>NO</b>		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>VIRGINIA TAYLOR 1524 MORELAND AVE.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic Obstructive Lung Disease</b> <b>4960</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>to 12-23-82</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>12-14-82</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Cor pulmonale</b>					
19a. DATE OF OPERATION <b>12/9/82</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>12/16/82</b> to <b>12/14</b> 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>12/14</b> 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>C. GAKUBA</b>		DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>12/27/82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>C. GAKUBA</b>		22e. ADDRESS <b>600 Reisterstown Rd. Pikesville Md 21208.</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>12-28-82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ARBUTUS MEM. PK.</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE MARYLAND</b>		24. FUNERAL DIRECTOR NAME ADDRESS <b>E.L. PHILLIPS 1721 N. MONROE ST.</b>			
25a. DATE REC'D. BY REGISTRAR <b>DEC 27 1982</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Smith</b>			



DECS 1982  
Lundquist

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 3-1-1.

FOR  
1 - STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) John W. Winter <i>John Winter</i>		2a. DATE OF DEATH MONTH DAY YEAR Dec 12 - 1982		2b. HOUR 5:20 PM	
3 SEX Male		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR 12 30 1903	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS.	
10 CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Baltimore City Hospital		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Air Craft Mechanic-Martins		12b. KIND OF BUSINESS OR INDUSTRY		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Edgemere	
14 FATHER'S NAME FIRST MIDDLE LAST Ernest Winter		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Keefer		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 215-12-7957		17. INFORMANT James E. Winter	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>4275 Cardio-Pulmonary Arrest</i> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		7839 North Cove Road Balto., MD. 21219	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>Dec 12</i> , 19 <i>82</i> , to <i>Dec 12</i> , 19 <i>82</i> , that (I) (we) lost saw the deceased alive on <i>Dec 12</i> , 19 <i>82</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Robin Fintel</i>		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <i>Dec 12 - 1982</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Robin Fintel</i>		22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/15/82		23c. NAME OF CEMETERY OR CREMATORY Oak Lawn	
23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland		24. FUNERAL DIRECTOR NAME Duda-Ruck, Inc. ADDRESS 7922 Wise Avenue Dundalk, MD. 21222			
25a. REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <i>John J. Carver</i>		DEC 14 1982	

RECEIVED  
INVESTIGATION DIVISION  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D.C.

8

DEC 14 1963  
JAMES EARL RAY

Items #1a-22a Film G575 1/27/83 rSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		MONTH		DAY		YEAR		2b. HOUR	
Margaret R. Wirth								ESTIMATED		12		1		1982		M	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR	
Female	White	April 10, 1957		25 YRS.						12		2		1982		1:25 a.m.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH									
Baltimore		USA		WIDOWED		DIVORCED		Baltimore City,								MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY											
Baltimore		407 E. Northern Pkwy., Apt. 26		Waitress		Restaurant											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS									
Maryland		-		Baltimore		YES		407 E. Northern Pkwy. Apt. 26									
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME															
John Church		Bertha McLeod															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT													
-		217-74-4913		Bertha Church, 3562 Dudley Avenue													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART 1 DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
9501		Secobarbital Intoxication		DUE TO, OR AS A CONSEQUENCE OF													
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.		(b)		DUE TO, OR AS A CONSEQUENCE OF													
(c)																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?		YES		NO									
21a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
WHILE AT WORK		12/1/1983		Subject ingested drug													
21d. INJURY OCCURRED WHILE AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION		CITY OR TOWN		COUNTY		STATE							
NOT WHILE AT WORK		Home		407 E. Northern Pkwy.		Baltimore		Md.									
22a. I certify that I took charge of the remains described above, held on death resulted from:		Autopsy		Inspection		Inquiry		and in my opinion									
Natural causes		Accident		Suicide		Homicide		Undetermined manner									
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED													
Dennis F. Smyth, M.D.		Assistant		12-2-82													
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS															
Dennis F. Smyth, M.D.		111 Penn Street															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		COUNTY		STATE							
Cremation		12/4/82		Greenmount Cem.		Baltimore		Maryland									
24. FUNERAL DIRECTOR NAME		25a. DATE RECEIVED BY REGISTRAR		25b. REGISTRAR'S SIGNATURE													
Schimunek Funeral Home		DEC 7 - 1982		John J. Smith													
3331 Brehms Lane, 21213																	
Baltimore, Md. 21213																	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL, TRANSIT PERMIT, PAGES 1 AND 2 SHOULD BE FILED IN YOUR FILES. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DEC 1 1950



STATE OF MARYLAND  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 CERTIFICATE OF DEATH

8 2 3 2 0 6 5

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>JOHN T. WISE</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>DECEMBER 7, 1982</b>			2b. HOUR <b>11:40P</b>			
3. SEX <b>M</b>		4. RACE <b>Negro</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>12 6 1900</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>82</b>		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>V.A.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.			
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION <b>THE JOHNS HOPKINS HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE <b>md.</b>		13b. COUNTY		13c. CITY OR TOWN <b>BAITO.</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>1727 E. Biddle ST.</b> #21213	
14. FATHER'S NAME FIRST MIDDLE LAST <b>ILLINAIS Wise</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Maggie ?</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>215-12-2880</b>		17. INFORMANT ADDRESS <b>DORIS ROBERTS 1727 E. Biddle ST.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>hypotension</b> <b>0389</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Sepsis</b> DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>Anemia, respirator dependent</b>									
9a. DATE OF OPERATION			9b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>Johns Hopkins Hospital</b>			
22a. I certify that (I) (this hospital) attended the deceased from <b>11/24/82</b> to <b>12/7/82</b> , that (I) (we) last saw the deceased alive on <b>12/7/82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Robert L. Redner MD</b>						DEGREE <b>MD</b>		22c. DATE SIGNED <b>12/8/82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Robert L. Redner MD</b>						22e. ADDRESS <b>Johns Hopkins Hospital</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b. DATE <b>12/11/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>EASTVIEW Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BAITO. md.</b>		
24. FUNERAL DIRECTOR NAME ADDRESS <b>BETTS Funeral Home 1129 N. Caroline ST.</b>						25a. DATE REC'D. BY REGISTRAR <b>DEC 9 1982</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Canine</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use on the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other violent cause, the medical examiner must be notified.



20



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW-3. RETURN PAGE 3 TO THE FUNERAL DIRECTOR. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE RETURNED TO THE DIVISION OF VITAL RECORDS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

Items #18a-22a Film 5755 1/17/83 re STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 3 2 0 6 6									
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2b. DATE OF DEATH		KNOWN <input type="checkbox"/> MONTH DAY YEAR ESTIMATED <input checked="" type="checkbox"/> 12 5 19 82		2b. HOUR			
Michael			D.			Wolff													
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED		2d. HOUR					
Male		Cau.		5 12 54		28 YRS.		MONTHS		DAYS		12 5 19 82		7:07					
7a. BIRTH PLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH							
Md.				U.S.A.								Baltimore City				MD.			
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY							
Baltimore				4221 Bayonne Avenue				Valu-Food				Stock Boy							
13a. STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS									
Md.						Balto.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		4221 Bayonne Ave. 21206									
14. FATHER'S NAME						15. MOTHER'S MAIDEN NAME													
FIRST MIDDLE LAST						FIRST MIDDLE LAST													
James M. Wolff						Dolores C. Franz													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS													
Yes				1977-78		213-66-8945		James M. Wolff 4221 Bayonne Ave.											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART I DEATH WAS CAUSED BY:																			
9520 IMMEDIATE CAUSE (a) Acute carbon monoxide intoxication																			
DUE TO, OR AS A CONSEQUENCE OF																			
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.																			
(b) DUE TO, OR AS A CONSEQUENCE OF																			
(c)																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																			
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?							
												YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH						21b. TIME OF INJURY						21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
						? P.M. 12/?/19 82						Self-ingested Subject inhaled fumes from car exhaust							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK						21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)						21f. LOCATION							
						Home						4221 Bayonne Ave. Baltimore Md.							
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																			
ACTUAL SIGNATURE						TITLE (SPECIFY)						DATE SIGNED							
Margarita A. Korell, MD						Assistant						12/5/82							
EXAMINER'S NAME (TYPE OR PRINT)						ADDRESS													
John C. Miller Inc. 6415 Belair Rd.						111 Penn Street, Balto. MD 21201													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)						23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION		COUNTY		STATE			
Burial						12-9-82		Gardens of Faith				Balto.		Balto.		Md.			
24. FUNERAL DIRECTOR NAME						ADDRESS						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
John C. Miller Inc. 6415 Belair Rd.												DEC 14 1982		[Signature]					



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGES 1 AND 2 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
OR A15 ME (1)  
20M 4/82

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE KNOWN OF DEATH			MONTH DAY YEAR			2b. HOUR							
NORMAN Kenneth WOLFF, Jr.						12 17 1982						M							
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		2d. HOUR					
Male		White		Aug. 28, 1947		35						12 17 1982		5:19 P M					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH							
Maryland				U.S.A.								Baltimore City MD.							
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY							
Baltimore				University Hospital				Auto Mechanic											
13a. STATE				13b. COUNTY				13c. CITY OR TOWN				13d. INSIDE CITY LIMITS?							
Maryland								Baltimore				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME				13e. STREET ADDRESS											
Norman K Wolff, Sr.				Betty E. Arthur				3408 White Ave.											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO.				17. INFORMANT				ADDRESS							
Yes				Vietnam				217-50-3229				Betty E. Wolff 9 Meadowood Box 39 Conowingo, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART I DEATH WAS CAUSED BY:																			
IMMEDIATE CAUSE (a) 8219 Cranio-cerebral injuries																			
DUE TO, OR AS A CONSEQUENCE OF																			
(b)																			
DUE TO, OR AS A CONSEQUENCE OF																			
(c)																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1																			
19a. DATE OF OPERATION								19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY?			
																YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH								21b. TIME OF INJURY								21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
noon P.M. 12-17-1982								Subject struck by tire rim.											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/>								21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)								21f. LOCATION			
service center								2912 Emmorton Rd., Bel Air, Harford Md.											
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion																			
TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER DATE SIGNED 12-18-82																			
EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D. ADDRESS 111 Penn St., Balto., Md. 21201																			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION							
Burial				12/22/82				Maryland Nat'l				Crownsville, Maryland							
24. FUNERAL DIRECTOR								25a. DATE REC'D. BY REGISTRAR								25b. REGISTRAR'S SIGNATURE			
NAME ADDRESS Leonard J Ruck Inc. Baltimore, Maryland								DEC 20 1982								J. G. Connel			

STANDARD

CHINA

WIA



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8-2 3 2 0 6 8

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>HENRY L. WONNEMAN</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>DECEMBER 1, 1982</b>		2b. HOUR <b>10:55<sub>AM</sub></b>
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Nov. 25, 1921</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>61</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.	
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>THE JOHNS HOPKINS HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Partner - Tavern Owner</b>		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Baltimore</b>	13c. STREET ADDRESS <b>3126 Greenmount Ave. 21218</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>George G. Wonneman</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary A. Pohl</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>WW II 215 12 3655</b>		17. INFORMANT ADDRESS <b>Mrs. Margaret Fee, Balto., MD 21213</b>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

4149

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause lost.

HYPERKALEMIA  
RENAL FAILURE / RAZDOLYSIS

DUE TO, OR AS A CONSEQUENCE OF

Sepsis

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

Respiratory Failure

19a. DATE OF OPERATION <b>11/15/82</b>	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Cranial Injury Dis</b>	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>1201 1st St. Balto. MD</b>	
22a. I certify that (I) (this hospital) attended the deceased from <b>12/1/82</b> to <b>12/1/82</b> , that (I) (we) lost saw the deceased alive on <b>12/1/82</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (we did) did not view the body after death.			
22b. SIGNATURE <b>Jeffrey H. Peters</b>		DEGREE <b>MD</b>	22c. DATE SIGNED <b>12/1/82</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Jeffrey H. Peters</b>		22e. ADDRESS <b>Johns Hopkins Hospital, Balto., MD</b>	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>12/4/82</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>Balto., MD</b>
24. FUNERAL DIRECTOR NAME <b>Henry W. Jenkins &amp; Sons Co.</b>		25a. DATE REC'D. BY REGISTRAR <b>DEC 2 - 1982</b>	25b. REGISTRAR'S SIGNATURE <b>John J. Canine</b>
4905 York Road Balto., MD 21212			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified about it.



CHIEF

200 COLT

WW II 215 12 2885 Mr. Margaret Poe, Balto., MD 21212  
George E. Womack, Mary A. Pool  
Maryland Baltimore x 215 Greenmount Ave. 21211  
U.S. THE COMPTON THE ECONOMIC Partner - Towns Green  
White Nov. 25, 1941 x

215 12 2885 Mr. Margaret Poe, Balto., MD 21212  
Henry W. Jantzen & Sons Co. Balto., MD 21211  
Johns Hopkins Hospital, Balto., MD

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

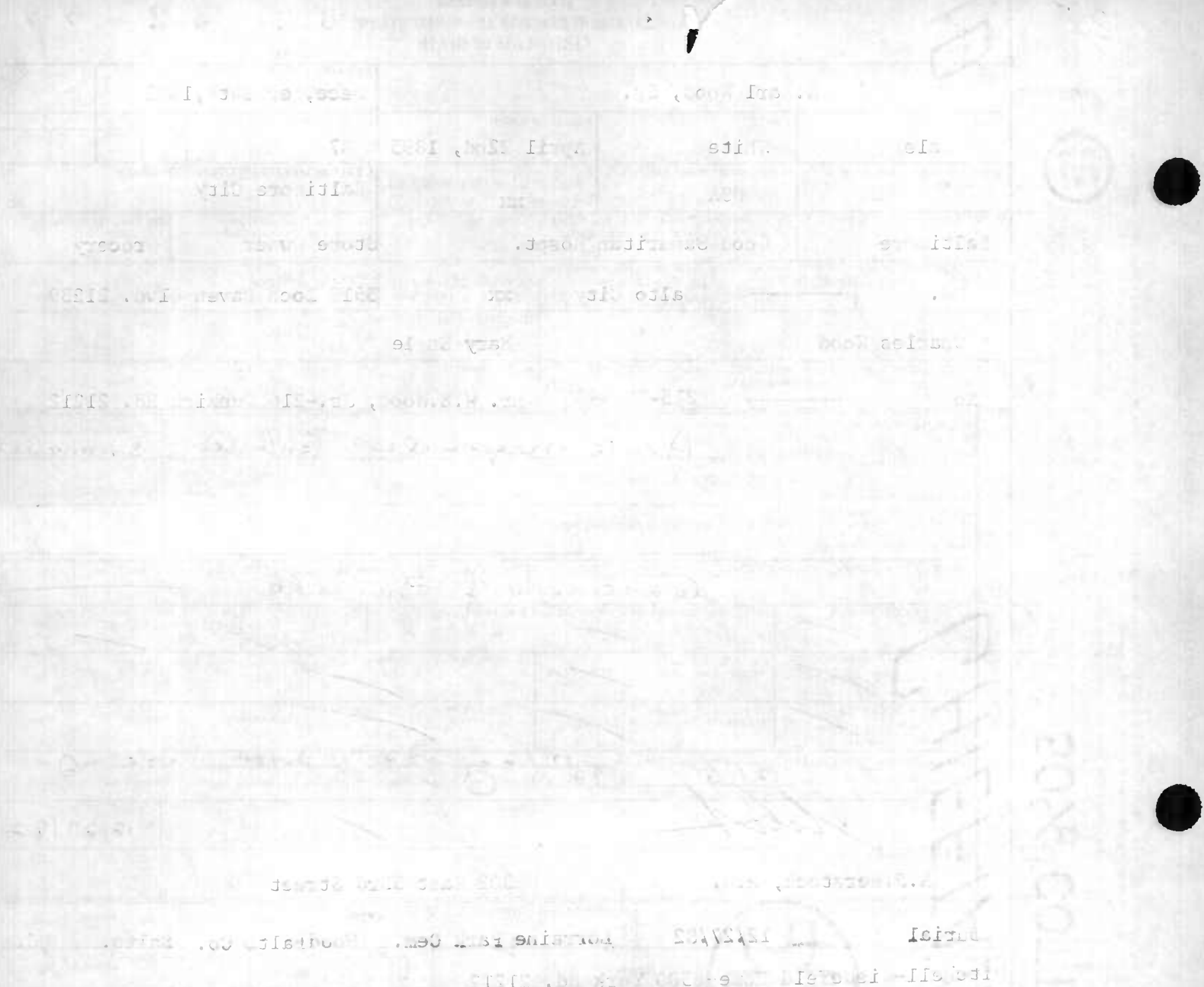
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with information on death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 2 3 2 0 6 9			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) W. Earl Wood				2a. DATE OF DEATH MONTH DAY YEAR December 24th, 1982		2b. HOUR M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR April 22nd, 1895		6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS.	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Good Samaritan Hospt.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Store Owner		12b. KIND OF BUSINESS OR INDUSTRY Grocery	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) Md.				13b. COUNTY Baltimore		13c. CITY OR TOWN Balto City	
14. FATHER'S NAME FIRST MIDDLE LAST Charles Wood				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Engle			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 215-32-9985		17. INFORMANT ADDRESS Mr. W.E. Wood, Jr.-216 Dunkirk Rd. 21212			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 4349 IMMEDIATE CAUSE (a) Acute myocardial Infarct DUE TO, OR AS A CONSEQUENCE OF (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Immediate	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a Leukemia of Pulate							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 11/22, 1982, to 12/24, 1982, that (I) (we) last saw the deceased alive on 12/16, 1982, and that (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE E.J. Berstock				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/27/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) E.J. Berstock, M.D.				22e. ADDRESS 302 East 33rd Street			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/27/82		23c. NAME OF CEMETERY OR CREMATORY Lorraine Park Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Woodlawn Balto. Md.	
24. FUNERAL DIRECTOR Mitchell-Wiedefeld Home-6500 York Rd. 21212				25a. DATE REC'D BY REGISTRAR DEC 27 1982			





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Joseph L. Woodland</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>12 1 82</b>		2b. HOUR M <b>AM</b>
3. SEX <b>male</b>	4. RACE <b>Black</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>3 3 12</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>70 YRS.</b>		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City, MD.</b>		
10. CITY OR TOWN OF DEATH <b>Baltimore</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>5430 Fairlawn Avenue</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>	13b. COUNTY	13c. CITY OR TOWN <b>Baltimore</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <b>5430 Fairlawn Ave. 21215</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>William Woodland</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Lillian Young</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>Yes</b>		16b. SOCIAL SECURITY NO. <b>218-03-8649</b>		17. INFORMANT ADDRESS <b>Julia E. Woodland 5430 Fairlawn Ave</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Brain tumor with</b> <b>2396</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Hypertension</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a <b>CHF 2° ACID compensated</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____ that (I) (we) last saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (where) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Juan A. Beltran</b>		DEGREE <b>M.D.</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>12/2/82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JUAN A. BELTRAN</b>		22e. ADDRESS <b>1940 W. BALTIMORE ST BALTIMORE, MD 21223</b>			
23a. BURIAL, CREMATION, REMOVAL <b>BURIAL</b>	23b. DATE <b>12/6/82</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Garden of Eternal</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Co. Md.</b>	
24. FUNERAL DIRECTOR NAME <b>Wm. C. March F/H Inc. 1101 E. North Avenue</b>		ADDRESS <b>DEC 3 - 1982</b>		25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <b>John J. Conner</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

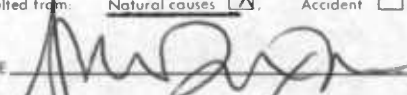
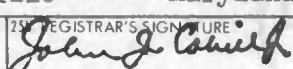
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 2 3 2 0 7 1			
FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>DANIEL ALBERT WOOTERS</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>DECEMBER 19, 1982</b>		2b. HOUR <b>8:45A</b>	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Dec. 25, 1947</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>34</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.	
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>THE JOHNS HOPKINS HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Sales Rep.</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Printing</b>	
13a. STATE <b>Maryland</b>				13b. CITY OR TOWN <b>Arundel Glen Burnie</b>		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>John A. Wooters</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Unknown</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>215-50-3187</b>		17. INFORMANT (Wife) ADDRESS <b>Mrs. Linda L. Wooters</b>		Same as #13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>2019</b> IMMEDIATE CAUSE (a) <b>respiratory failure</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>hodgkins disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>radiation pulmonary fibrosis, malignant pleural effusion</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>11/15</b> 19 <b>82</b> , to <b>12/19</b> 19 <b>82</b> , that (I) <input checked="" type="radio"/> saw the deceased alive on <b>12/19</b> 19 <b>82</b> , and that in (my) <input checked="" type="radio"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="radio"/> did <input type="radio"/> did not view the body after death.							
22b. SIGNATURE <b>H. Langevin MD</b>				DEGREE <b>MD</b>		22c. DATE SIGNED <b>12/19/82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DR H. LANGEVIN</b>				22e. ADDRESS <b>JOHNS HOPKINS HOSPITAL</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>December 22, 1982</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Meadowridge Mem. Pk</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Elkridge Howard Md.</b>	
24. FUNERAL DIRECTOR NAME <b>R. N. Hopkins</b>				25a. DATE REC'D. BY REGISTRAR <b>DEC 21 1982</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Lander</b>	
24. FUNERAL HOME <b>Singleton Funeral Home, Glen Burnie, Md.</b>							

107 15-111

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE MEDICAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

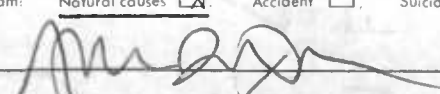
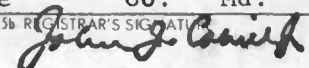
DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 3 2 0 7 2	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ARTHUR R. WOODWARD										2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR 12 21 19 82	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Dec. 4, 1921		6. AGE (IN YEARS) (LAST BIRTHDAY) MONTHS DAYS HOURS MIN. 61 YRS.		7c. DATE PRONOUNCED DEAD 12 21 1982		2b. HOUR 2:05 PM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD	
10. CITY OR TOWN OF DEATH Baltimore				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Church Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Policeman Ret.		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland				13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS Balt., Md. 21231 1930 Bank Street	
14. FATHER'S NAME FIRST MIDDLE LAST William Woodward						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Not Known					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes				(IF YES, GIVE WAR OR DATES) WW II		16b. SOCIAL SECURITY NO. 215-12-0277		17. INFORMANT ADDRESS Balt. 21231 Richard R. Gallagher 1930 Bank St.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). <u>Arteriosclerotic cardiovascular disease</u> 4292 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE 				TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER				DATE SIGNED 12-22-82			
EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D.				ADDRESS 111 Penn St., Balto., Md. 21201							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE Dec 28 1982		23c. NAME OF CEMETERY OR CREMATORY Maryland Veterans				23d. LOCATION CITY OR TOWN COUNTY STATE Crownsville Maryland	
24. FUNERAL DIRECTOR NAME Leonard J. Ruck, Inc.						ADDRESS Baltimore, Maryland		25a. DATE REC'D. BY REGISTRAR DEC 23 1982		25b. REGISTRAR'S SIGNATURE 	

John G. ... 2020 231



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY OCCURS, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 WITH YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND										2		3 2 0 7 3	
DEPARTMENT OF HEALTH AND MENTAL HYGIENE													
MEDICAL EXAMINER'S CERTIFICATE OF DEATH													
1- FOR STATE REGISTRAR										REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST HOWARD E. WREN										2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR 12 21 19 82		2b. HOUR M	
3. SEX male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 8 28 47		6. AGE (IN YEARS) LAST BIRTHDAY 35 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 12 21 19 82		7d. HOUR P M 7:44	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.			
10. CITY OR TOWN OF DEATH Baltimore				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 211 Mt. Holly St.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)													
13a. STATE Maryland		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 211 Mt. Holley Street 21229					
14. FATHER'S NAME FIRST MIDDLE LAST Howard Wren					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Muriel Parker								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. N/A		17. INFORMANT ADDRESS Weldon Wren Jr. 211 Mt. Holley St.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cirrhosis of the liver</u> 5715 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE 				TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER				DATE SIGNED 12-22-82					
EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D.				ADDRESS 111 Penn St., Balto., Md. 21201									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL				23b. DATE 12/27/82		23c. NAME OF CEMETERY OR CREMATORY Mount Zion Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Co. Md.					
24. FUNERAL DIRECTOR NAME Wm. C. March F/H Inc. 1101 E. North Avenue						25a. DATE REC'D BY REGISTRAR DEC 23 1982		25b. REGISTRAR'S SIGNATURE 					

RECEIVED  
IN THE OFFICE OF THE  
ATTORNEY GENERAL  
STATE OF NEW YORK

5

RECEIVED

NOV 20 1933



DEC 3 1933

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>LAURA</b> <b>Wright</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>12-22-82</b>			2b. HOUR <b>12:40</b> P.M.				
3. SEX <b>FEMALE</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>6 22 84</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>99</b> YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>N. CAROLINA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.				
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (GIVE STREET ADDRESS) <b>FEDERAL Hill Nsg Center</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (GIVE STREET ADDRESS) <b>N. Carolina</b>			13b. COUNTY <b>BALTO.</b>		13c. CITY OR TOWN <b>BALTO.</b>		13d. INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>2509 Garrison Blvd.</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>UNKNOWN</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>UNKNOWN</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. <b>174 32 6094</b>		17. INFORMANT ADDRESS <b>Florence Hall 5100 Willistm St.</b>					

18. CAUSE OF DEATH (Enter only one cause per line for 18a, 18b, and 18c.)  
PART 1. DEATH WAS CAUSED BY:

4100

IMMEDIATE CAUSE (a) **Coronary Insufficiency**

DUE TO, OR AS A CONSEQUENCE OF

(b) **ASCVD**

DUE TO, OR AS A CONSEQUENCE OF

(c) **ASCVD**APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

## MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>8/9/78</b> to <b>12/22/82</b> , that (I) (we) lost <b>12/22/82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>K.C. Keener</b>		DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>12/22/82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>K.C. Keener</b>		22e. ADDRESS					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>12-29-82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Zion Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Lanham Md.</b>	
24. FUNERAL DIRECTOR NAME <b>Joseph L. Russ</b> ADDRESS <b>2222 W. North Ave.</b>				25a. DATE REC'D. BY REGISTRAR <b>DEC 27 1982</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Conner</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the deceased, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



DEC 27 1952  
JAMES EARL RAY

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 1 FOR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED IN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 3 2 0 7 5	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) <b>Pearse Wright</b>						2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>12 16 1982</b>		2b. HOUR <b>9:45 a.m.</b>			
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>11 16 26 56 YRS.</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>56 YRS.</b>		7. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>12 16 1982</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>				7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City,</b> MD.	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>3333 N. Charles Street - rear</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Maryland</b>				13b. COUNTY		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>3333 N. Charles St. 21218</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Clarence Wright</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Blanche Choate</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>Yes</b>				16b. SOCIAL SECURITY NO. <b>WW II 218-28-2275</b>		17. INFORMANT ADDRESS <b>Mrs. Lori Hardy 728 Cliffedge Rd. 21208</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: <b>9570 Multiple Injuries</b> IMMEDIATE CAUSE (a) <b>Multiple Injuries</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>9:30xx 12 16 1982</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>subject jumped from building</b>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>alley</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>3333 N. Charles St., Baltimore, Maryland</b>					
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <i>Dennis F. Smyth</i>				TITLE (SPECIFY) M.D. <b>Assistant</b>				DATE SIGNED <b>12-16-82</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>Dennis F. Smyth, M.D.</b>				ADDRESS <b>111 Penn Street</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>				23b. DATE <b>12/17/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Security Process</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Maryland</b>	
24. FUNERAL DIRECTOR NAME <b>A. Alan Seitz, Jr.</b>						ADDRESS <b>3818 Roland Ave. 21211</b>		25a. DATE REC'D. BY REGISTRAR <b>DEC 21 1982</b>		25b. REGISTRAR'S SIGNATURE <i>John J. Lauer</i>	

A. Alan Peitz, Jr. 3816 Roland Ave. 21211

Creation 12/1/72 Security Process Baltimore Maryland

Yes WW II 214-2-2245 Mrs. Lori Hardy 158 Cliffield Rd. 21208

Clarence Wright Elanora Chicago

Maryland Baltimore x 3333 N. Charles St. 21218

Maryland USA x

Male White 11 10 26 26

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										
CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR					REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>William F. Xander</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>12 7 82</b>					2b. HOUR <b>4:00A</b>
3. SEX <b>Male</b>		4. RACE <b>Cau.</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>8 11 94</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>88</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Germany</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.				
10. CITY OR TOWN OF DEATH <b>Balto.</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>3900 Southern Ave.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Tavern Owner</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>		
13a. STATE <b>Md.</b>		13b. COUNTY <b>-</b>		13c. CITY OR TOWN <b>Balto.</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>3900 Southern Ave. 21206</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Gottlieb Xander</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>unknown</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>no</b>		16b. SOCIAL SECURITY NO. <b>216-03-6005</b>		17. INFORMANT ADDRESS <b>Helena R. Xander 3900 Southern Ave.</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Ischemic Heart Disease</b> <b>4149</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <b>11-24</b> 19 <b>82</b> , to <b>11</b> 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>11-24</b> 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not view the body after death, so state.)										
22b. SIGNATURE <i>[Signature]</i>					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>12-11-82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Balto. Md.</b>				
24. FUNERAL DIRECTOR NAME ADDRESS <b>John C. Miller Inc. 6415 Belair Rd.</b>					25a. DATE REC'D. BY REGISTRAR <b>DEC 14 1982</b>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			





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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral home, it should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 48 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE						8 2 3 2 0 7 7						
1. FOR STATE REGISTRAR			CERTIFICATE OF DEATH			REG. NO.						
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR
EUNICE G YAKEL						12 27 82						6 <sup>55</sup> A.M.
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.		
Female		White		MONTH DAY 1910 Sept 3, 1910		72 YRS		MONTHS DAYS HOURS MIN.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH						
Maryland		U.S.A.				BALTIMORE CITY MD.						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
BALTIMORE		UNION MEMORIAL HOSPITAL						Retired Book Keeper				
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
Maryland					Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		6506 Sefton Ave 21214			
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME									
FIRST MIDDLE LAST Louis Layfield			FIRST MIDDLE LAST Lydia Green									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS							
No			212-03-9607		Mrs Sandra G Thomas 524 Applewood Dr Bel Air, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												
PART 1. DEATH WAS CAUSED BY:												
IMMEDIATE CAUSE (a) <u>RESPIRATORY ARREST</u>												
1749 DUE TO, OR AS A CONSEQUENCE OF												
(b) <u>BREAST CA, METS, -P LUNGS</u>												
DUE TO, OR AS A CONSEQUENCE OF												
(c)												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
NA			NA			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
					NA							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
			NA		NA							
22a. I certify that (I) (this hospital) attended the deceased from <u>12/15</u> , 19 <u>82</u> , to <u>12/27</u> , 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>12/26</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED			
<u>S Riggio</u>									12/27/82			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS									
S RIGGIO - JAGODA			UNION MEMORIAL HOSPITAL									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
Burial			12/30/82		Gardens Of Faith		Baltimore, Maryland					
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
Leonard J Ruck Inc.			Baltimore, Maryland			DEC 28 1982		<u>John J. Canish</u>				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at the

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8-2 3 2 0 7 8		
1. FOR STATE REGISTRAR			REG. NO.									
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH			MONTH DAY YEAR		2b. HOUR	
EDNA A. YATES						December 29, 1982					330 M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 74 HRS		
Female		White		MONTH DAY YEAR 10 4 1910		72 YRS.		MONTHS DAYS		HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH						
Maryland		USA				Baltimore City MD.						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
Baltimore		2000 Odell Avenue Apt. 904						Homemaker		Own Home		
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
Maryland					Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		2000 Odell Ave. 21237			
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME									
FIRST MIDDLE LAST Walter Beach			FIRST MIDDLE LAST Edna Haynes									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT			ADDRESS				
No			219 05 5584		Luther B. Yates,			Same				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
IMMEDIATE CAUSE (a) Probable Arrhythmia										Sudden Death		
DUE TO, OR AS A CONSEQUENCE OF (b) Coronary Artery Disease.										>5yrs		
DUE TO, OR AS A CONSEQUENCE OF (c) End-stage Renal Disease										>5yrs		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (If hospital) attended the deceased from July 13, 1978, to Dec 29, 1982, that (I) (we) lost saw the deceased alive on Dec 29, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED			
Edward Seth Kraus MD			MD						12/30/82			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS									
Edward Seth Kraus MD			Baltimore City Hospitals 4740 Eastern Ave, Baltimore MD									
23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
Cremation			12/30/82		Green Mount		Baltimore, MD					
24. FUNERAL DIRECTOR NAME ADDRESS Henry W. Jenkins & Sons Co. 4905 York Road Balto., MD 21212						25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE DEC 30 1982 John J. Smith						



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner will be called at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8	2	3	2	0	7	9
1- FOR STATE REGISTRAR										REG. NO.						
1. DECEASED NAME (TYPE OF PRINT) FIRST MIDDLE LAST <b>Lillian Frances Zavodny</b>										2a. DATE OF DEATH MONTH DAY YEAR <b>December 11, 1982</b>				2b. HOUR <b>6:00</b> A.M.		
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Jan. 28 1922</b>				6. AGE (IN YEARS LAST BIRTHDAY) <b>60</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.				
7a. BIRTHPLACE (COUNTRY) STATE OR FOREIGN <b>W. Va.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.								
10. CITY OR TOWN OF DEATH <b>Baltimore</b>				11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>3515 Juneway</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Deli Clerk</b>				12b. KIND OF BUSINESS OR INDUSTRY <b>Food Fair</b>				
13a. STATE <b>Md.</b>		13b. COUNTY <b>-</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>3515 Juneway 21213</b>								
14. FATHER'S NAME FIRST MIDDLE LAST <b>David Anderson</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Etta Dunivant</b>											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. <b>234-24-7485</b>		17. INFORMANT ADDRESS <b>Jerome Zavodny (husband) same address</b>												
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory Failure</b> <b>1629</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Squamous Cell Ca of the Lung.</b> DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE										
22a. I certify that (I) (the hospital) attended the deceased from <b>Dec 1</b> 19 <b>82</b> , to <b>Dec 11</b> 19 <b>82</b> , that (we) last saw the deceased alive on <b>Dec 11</b> 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																
22b. SIGNATURE <b>George Taler</b>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>12/13/82</b>								
22d. PHYSICIAN'S NAME (TYPE OF PRINT) <b>Dr. George Taler</b>				22e. ADDRESS <b>600 Light Street</b>												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>12/14/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gardens of Faith</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Md.</b>								
24. FUNERAL HOME (NAME AND ADDRESS) <b>Schimunek Funeral Home, Inc. 3331 Brehms Lane, Balto. Md. 21213</b>						25a. DATE REC'D. BY REGISTRAR <b>DEC 14 1982</b>										
						25b. REGISTRAR'S SIGNATURE <b>Jan J. Conner</b>										

1000



NOTICE

Notice is hereby given that the undersigned has been appointed by the Court of Sessions of the County of ...

11th Dec 1891  
James W. ...



## CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Edna M. Zeitler		2a. DATE OF DEATH MONTH DAY YEAR 12-10-82		2b. HOUR 10 <sup>45</sup> P.M.	
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR July 6, 1890		6. AGE (IN YEARS LAST BIRTHDAY) 92	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Provident Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Home Maker		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Maryland	13b. COUNTY	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 3007 Milford Avenue 21207	
14. FATHER'S NAME FIRST MIDDLE LAST Francis D. Fenneman		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sarah Brown			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 213-60-4300		17. INFORMANT ADDRESS Edgewood, Md. Doris Berry 1412 Willow Oak Rd. 21040	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u> 2765 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Dehydration - ASCVD</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>12-06-1982</u> to <u>12-10-1982</u> , that (I) (we) lost saw the deceased alive on <u>12-10-1982</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE H. Devadoss - MD		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12-10-82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) H. Devadoss		22e. ADDRESS Provident Hospital			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE Dec 14 1982	23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland	
24. FUNERAL DIRECTOR NAME Leonard J. Ruck, Inc.		ADDRESS Baltimore, Maryland		25a. DATE REC'D. BY REGISTRAR DEC 13 1982	25b. REGISTRAR'S SIGNATURE John J. Conner

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 7 days with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 2 3 2 0 8 1			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Edward C. Zellmer</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>12 23 82</b>		2b. HOUR <b>09:55<sup>A</sup></b>	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>8 9 01</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>81</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>St. Agnes Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Lab.</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>DCA Foods</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Howard</b>		13c. CITY OR TOWN <b>Ellicott City</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>John M. Zellmer</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Katie Sewell</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>213 107 988</b>	
17. INFORMANT <b>Elmer Zellmer Ellicott City Md 21043</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>4416</b> IMMEDIATE CAUSE (a) <b>Ruptured aortic aneurysm</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Atherosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Arteriosclerotic cardiovascular disease &amp; old myocardial infarct</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>0852 P.M. 12 23 82</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>Abd. Pain, Nausea</b>			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <b>home</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>877 Oella Ave. Ellicott City Howard Md.</b>			
22a. I certify that (I) (this hospital) attended the deceased from <b>12/23</b> 19 <b>82</b> to <b>12/23</b> 19 <b>82</b> , that (I) (we) <input checked="" type="checkbox"/> lost saw the deceased alive on <b>12/23</b> 19 <b>82</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) <input checked="" type="checkbox"/> did not view the body after death.							
22b. SIGNATURE <b>William J. Hicken, MD</b>				22c. DEGREE <b>MD</b>		22d. DATE SIGNED <b>12/23/82</b>	
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <b>W.M. J. HICKEN</b>				22f. ADDRESS <b>St Agnes Hosp.</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>12-27-82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Good Shepherd Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Ellicott City Howard Md</b>	
24. FUNERAL DIRECTOR NAME <b>Slack F.H. Ellicott City Md 21043</b>				25a. DATE REC'D. BY REGISTRAR <b>DEC 28 1982</b>		25b. REGISTRAR'S SIGNATURE <b>Jo Ann J. Gammish</b>	

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• *For more information, call 1-800-451-7237.*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Registrar of the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST SR <b>AUGUST H. ZIEGLER SR</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>12 19 82</b>				2b. HOUR <b>6:53a</b>	
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>2 3 20</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>62</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
8. PLACE OF BIRTH (STATE OR FOREIGN) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.			
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>ST. AGNES HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>LETTER CARRIER</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>U.S. POSTAL</b>	
13a. RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY <b>MARYLAND BALTIMORE</b>				13c. CITY OR TOWN <b>ARBUTUS</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>1134 ELM ROAD, 21227</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>AUGUST O. ZIEGLER</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>LENA KAHR</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>WW II</b>		17. INFORMANT <b>DOLORES M. ZIEGLER</b>		ADDRESS <b>1134 ELM ROAD, 21227</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4100 IMMEDIATE CAUSE (a) <b>Cardio-Respiratory arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Myocardial infarction</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Hypertensive Heart disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Surgery</b>									
19a. DATE OF OPERATION <b>12-17-82</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>CBD-obstruction by stone</b>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>12-12-1982</b> , to <b>12-19-1982</b> , that (I) (we) last saw the deceased alive on <b>12-19-82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Merchant Deepak</b>				DEGREE <b>MD</b>				22c. DATE SIGNED <b>12-19-82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>MERCHANT, DEEPAK P.</b>				22e. ADDRESS <b>3350 WILKENS AVENUE, BALTO, MD 21229</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>12-22-82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>CREST LAWN MEM. GAR.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>MARRIOTTSTVILLE HOWARD MD.</b>			
24. FUNERAL DIRECTOR NAME <b>HUBBARD FUNERAL HOME, INC.</b>				ADDRESS <b>4107 WILKENS AVE.</b>		24. DATE RECEIVED BY REGISTRAR <b>DEC 20 1982</b>		REGISTRAR'S SIGNATURE <b>John J. [Signature]</b>	

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY CHANGES ARE NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE PLACED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE KNOWN OF DEATH			2b. HOUR		
ROBERT J. ZIMMER			12 9 19 82			M		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	IF UNDER 1 YR.	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD		
Male	White	June 2, 1924	58 YRS.			12 9 19 82		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		
Wisconsin		U.S.A.				Baltimore City		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Baltimore		1933 Eastern Ave.			Driver		Taxi	
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
Md.					Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16. SOCIAL SECURITY NO.		
Rudolph Zimmer			Ione Martha Halstead			577-26-2200		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS		
Yes			WWII			Bonnie Woodall 2062 Knoll View Dr. (21122)		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I DEATH WAS CAUSED BY:								
IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease								
4292								
DUE TO, OR AS A CONSEQUENCE OF								
(b)								
DUE TO, OR AS A CONSEQUENCE OF								
(c)								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?	
							YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
			HOUR A.M. MONTH DAY YEAR					
			P.M. 19					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION			
					CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE			TITLE (SPECIFY)			DATE SIGNED		
Ann M. Dixon, M.D.			M.D. Assistant			12-10-82		
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS					
Ann M. Dixon, M.D.			111 Penn St., Balto., Md. 21201					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		
Burial		12/14/82		Md. Vet's. Cemetery		Crownsville Md.		
24. FUNERAL DIRECTOR NAME			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
George J. Gonce F.H. 4001 Ritchie Hwy.			DEC 20 1982			John J. Carver		

0203



1. Name of the person or organization to whom the letter is addressed  
2. Address of the person or organization to whom the letter is addressed  
3. City, State, and Zip Code of the person or organization to whom the letter is addressed  
4. Date of the letter  
5. Salutation  
6. Body of the letter  
7. Closing  
8. Signature  
9. Enclosures  
10. Distribution list

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 2 3 2 0 8 4	
1- FOR STATE REGISTRAR				REG. NO.	
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST REBECCA N. ZIMMERMAN			2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 17, 1982		2b. HOUR 2:45 AM
3 SEX FEMALE	4 RACE WHITE	5 DATE OF BIRTH MONTH DAY YEAR SEPT. 5, 1890		6 AGE (IN YEARS LAST BIRTHDAY) 92 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) RUSSIA	7b. CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10 CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 6424 ELRAY DR., APT. D		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY AT HOME
13a. STATE MARYLAND		13b. COUNTY	13c. CITY OR TOWN BALTIMORE	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST BENJAMIN FEINBERG			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST SARAH UNKNOWN		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 220-44-4533		17 INFORMANT MR. RAYMOND ZIMMERMAN APT. 902 302 E. JOPPA RD. TOWSON, MD 21204	
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac failure</u> 4140 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) <u>a.s.H.D. - Hypertension</u> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hour 10 years					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c) <u>Carcinoma of colon</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>Nov. 50</u> to <u>present</u> 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Bernard Burgin M.D.</u>		DEGREE M.D.		22c. DATE SIGNED 12/17/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BERNARD BURGIN, M.D.		22e. ADDRESS 3809 Clarke Lane Balto. Md. 21215			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE DEC. 19, 1982		23c. NAME OF CEMETERY OR CREMATORY BETH TFILOH	
23d. LOCATION BALTIMORE		COUNTY MARYLAND			
24 FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215			25a. DATE REC'D. BY REGISTRAR DEC 21 1982		
25b. REGISTRAR'S SIGNATURE <u>John J. Connel</u>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 1B show any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 2 3 2 0 8 5			
1. FOR STATE REGISTRAR				CERTIFICATE OF DEATH			
1. DECEASED NAME (TYPE OR PRINT) MARGARET A. ZINK				2a. DATE OF DEATH MONTH DAY YEAR 12-2-82			
3 SEX Female				2b. HOUR 1 P. M.			
4. RACE CAUC				5. DATE OF BIRTH MONTH DAY YEAR 7 10 98			
6a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.				6 AGE (IN YEARS LAST BIRTHDAY) 84			
7b. CITIZEN OF WHAT COUNTRY? U.S.A.				9 BALTIMORE CITY OR COUNTY OF DEATH BALTO. CITY MD			
10 CITY OR TOWN OF DEATH BALTIMORE				11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3335 LAWNVIEW AVE 21213			
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE				12b. KIND OF BUSINESS OR INDUSTRY AT HOME			
13a. STATE MD				13b. COUNTY -			
13c. CITY OR TOWN BALTIMORE				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST CHARLES MUSIL				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ROSE (UNKNOWN)			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 212-74-3817			
17. INFORMANT ADDRESS HERMAN MAREZ 1513 WEYBURN RD 21237							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4140 IMMEDIATE CAUSE (a) Atherosclerotic Heart Disease							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH years-
DUE TO, OR AS A CONSEQUENCE OF (b)							
DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			
20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>				20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			
21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 7/19, 19 79, to 12/2, 19 79, that (we) last saw the deceased alive on 9/19, 19 79, and that in (a) (a) apian death occurred on the date and hour and from the causes stated above, (b) (we) (did) (did not) view the body after death.							
22b. SIGNATURE				22c. DATE SIGNED 12-3-82			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) GEORGE E. LOWE MD				22e. ADDRESS 3703 BELAIE RD BALTO. MD 21213			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL				23b. DATE 12-6-82			
23c. NAME OF CEMETERY OR CREMATORY BOHEMIAN NATIONAL				23d. LOCATION CITY OR TOWN COUNTY STATE BALTO MD			
24. FUNERAL DIRECTOR NAME SCHIMUNEK FUNERAL HOME 3331 BREHNS LA.				25a. DATE RECD. BY REGISTRAR DEC 7 - 1982			
				25b. REGISTRAR'S SIGNATURE John J. Canick			

DEC 7 - 1965

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 3 2 0 8 6			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH			
FIRST MIDDLE LAST <b>Irene Zisk</b>				MONTH DAY YEAR <b>12 13 1982</b>			
3. SEX				2b. HOUR			
<b>Female</b>				<b>M</b>			
4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR	
<b>Cuac.</b>		MONTH DAY YEAR <b>11 26 1917</b>		<b>65</b> YRS.		IF UNDER 24 HRS	
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
<b>Md.</b>		<b>U.S.A.</b>		<b>Baltimore City</b>		<b>MD.</b>	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
<b>Baltimore</b>		<b>516 N. Streeper St.</b>		<b>Housewife</b>			
13a. STATE				13b. CITY OR TOWN			
<b>Md.</b>				<b>Baltimore</b>			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME			
FIRST MIDDLE LAST <b>Joseph Kraig</b>				FIRST MIDDLE LAST <b>Unknown</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.			
<b>No</b>				<b>212-36-4226</b>			
17. INFORMANT				ADDRESS			
<b>No</b>				<b>Pricilla Robinson 209 N. Rose St.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>metastatic carcinoma - liver</b> <b>1533</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Carcinoma sigmoid colon</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>1 yr</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>Oct 27</b> , 19 <b>82</b> , to <b>Oct 27</b> , 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>Oct 27</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE <b>Charles B MacNimm MD</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>12/15/82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
<b>Burial</b>		<b>12/16/82</b>		<b>Oak Lawn Cem.</b>		<b>Baltimore Md.</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>B. Dabrowski &amp; Son 2818 E. Baltimore St.</b>				25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <b>DEC 20 1982 John J. Connel</b>			

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